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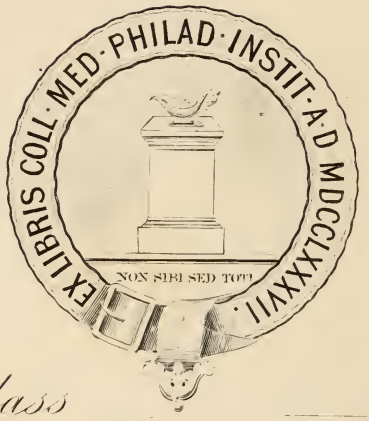

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E. J. Reichert, M.D.

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TRANSACTIONS

OF THE

TWENTY-SEVENTH SESSION

OF THE

HOMŒOPATHIC MEDICAL SOCIETY

OF THE

STATE OF PENNSYLVANIA.

HELD AT PITTSBURGH, SEPTEMBER 15, 16, 17, 1891.

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18915

To the Homœopathic Medical Society of the State of Pennsylvania:

The Proceedings and Papers of the Twenty-seventh Session are hereby respectfully submitted.

Edward R. Snader, M.D.,
J. Richey Horner, M.D.,
J. F. Cooper, M.D.,
Committee on Publication.

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PROCEEDINGS

OF THE

TWENTY-SEVENTH SESSION

OF THE

HOMŒOPATHIC MEDICAL SOCIETY

OF THE

STATE OF PENNSYLVANIA.

PITTSBURGH, PA., September 15th, 16th and 17th, 1891.

THE Twenty-seventh Session of the Homœopathic Medical Society of the State of Pennsylvania convened in the Assembly Room of the Homœopathic Hospital of Pittsburgh, on Tuesday, September 15, 1891, at 10 o'clock A.M.

The meeting was called to order by the President, August Korndœrfer, M.D., of Philadelphia.

Rev. JOSEPH HORNER, D.D., of Pittsburgh, invoked the Divine blessing on the proceedings and actions of the Convention.

CHARLES H. HOFFMAN, M.D., President of the Homœopathic Medical Society of Allegheny County, welcomed the delegates in the following address:

Mr. President, Members of the Homœopathic Medical Society of the State of Pennsylvania:

LADIES AND GENTLEMEN.—The Allegheny County Homœopathic Medical Society considers it always an honor to have you

meet together within the limits of its home, and has delegated me to most heartily bid you welcome.

We, as members of the County Society, are proud of the fact that the State Society had its beginning here, the first meeting having been held here on the 5th of June, 1866. Since that time the County Society has a number of times welcomed you here, but at no time more heartily than the present.

The meeting of representatives of such a large and influential body as is the State Society is always fraught with benefit and profit, not only to the members in attendance, but also to the absent ones. These latter, while prevented from enjoying directly the papers read and discussions called forth, are nevertheless the gainers when they receive the *Annual Transactions*. And, too, the knowledge that a number of their brothers are in session together must surely kindle a fire of enthusiasm within them and stimulate them to renewed efforts in the ever grand and glorious work of practicing and disseminating the principles of our law. So, too, is its influence felt within the community in which such a meeting is held. The reports made through the medium of the daily press are eagerly looked for and read by the thousands who are adherents of Homœopathy, and thus the influences for good are wide-reaching in their effects. So it is that these annual meetings are so replete in their good and long-lasting results.

In welcoming you we are reminded of the hearty, very hearty, welcomes we have received from you in past years, and if you, on your return to your homes, carry with you one-half the pleasant recollections we brought with us, we shall be more than satisfied.

Thanking you for your kind attention and hoping that the meetings to follow may prove of great interest and profit to all, I again give to you a most hearty welcome.

W. G. Dietz, M.D., of Hazleton, responded, on behalf of the visiting members, as follows :

Mr. Chairman and Members of the Allegheny County Homœopathic Medical Society:

It is with feelings of the greatest pleasure that we come to Pittsburgh. The name of your city is a synonym of generosity,

hospitality and pleasure. When we come to Pittsburgh we are sure of having a meeting which will be at once profitable and pleasurable, and of having the meeting preceded by a welcome as hearty and true as that to which we have just listened. We are favored, too, in having for our place of meeting the assembly-room of an hospital whose name is known wherever Homœopathy is known. We are inspired by the memories of the grand and noble work accomplished here, and I am sure that none of us but will be enabled by the inspiration of those memories to bring to you our best thoughts and most instructive knowledge.

In the name of the visiting members I thank you for your cordial welcome, and believe that the closing of the sessions of this convention will find us with the feeling that we have gained that which will enable us to do better work for Homœopathy, our patients and ourselves. Again I thank you.

The President, Dr. Korndœrfer, called the First Vice-President, Dr. E. C. Parsons, of Meadville, to the chair, and then delivered the

PRESIDENT'S ANNUAL ADDRESS.

Ladies and Gentlemen, Members of the Homœopathic Medical Society of the State of Pennsylvania:

In accordance with the rules of this Society it becomes my duty, and is my pleasure, to address you to-day upon matters of interest to us all, as members of the Homœopathic school of medicine.

Representing a system now nearing the close of its first century, a system that has successfully withstood all opposition, we, both as individuals and in our corporate capacity, have devolving upon us constantly increasing responsibilities—as individuals, to aid in the development of the science of medicine; as a corporate body, to maintain that freedom of thought and opinion which is the life of science and progress.

Ridicule, slander, and false accusations have been, and still are, unstintingly employed in efforts to weaken, and, if possible, to destroy our influence. Nevertheless we, to-day, stand more securely established than at any period since Hahnemann announced the law.

Our school is making progress, both rapidly and surely; in illustration of which we need but refer to the brilliant success attending the fourth quinquennial meeting of the International Homœopathic Congress, held at Atlantic City, June last.

The results of that meeting should prove sufficient to convince even the most obdurate of our opponents, that the application of the "law of similars" has been followed by such unqualified success, that they dare not, with any hope of being accredited with either ordinary powers of perception, or average love of truth, suggest the idea of quackery or fraud as pertaining to the conduct of those who believe and practice in accordance with that law.

The sessions of the International Congress were full of interest to every lover of Homœopathy. Many valuable papers were presented, and the discussions elicited were marked by perspicuity, erudition, and freedom from all partisan prejudice. On some subjects most diverse views were earnestly and vigorously maintained, yet without being marred by the slightest tinge of rancor. In fact, the sessions were marked throughout by thoroughly systematized order and fraternal feeling, reflecting credit not only upon the members, but equally upon the judgment and ability of the presiding officer.

The bitter wail of disappointment, freely mingled with terms of disparagement, which ascended from the editorial sanctums of a few of our most implacable journalistic opponents, bears evidence of the good work done. Had this meeting not proved so grand a success, it would have received but scant mention by any of them. Their ill-considered, obtuse sarcasm would have found expression without encroaching upon the valuable (*sic*) space of their editorial columns.

The general tenor of these editorials betrays the fact that their authors are absolutely ignorant of the beneficent effects of Homœopathy. These critics surely constitute a portion of that class, of whom it may well be said, "they forget nothing," simply because "they learn nothing."

In addition to the importance justly to be attached to the scientific features of the work of the International Congress, we ought not to overlook the fact that it was also an important factor in developing a more sympathetic relationship between sections geo-

graphically widely separated, a result highly important at this present juncture, in relation to the welfare, yea, even the very autonomy of our school, for no hope is dearer to many of our opponents than that the Homœopathic school shall ultimately be destroyed.

Verily this meeting of the International Congress tended mightily toward the strengthening of our school, both at home and abroad.

Of the many home interests upon which I should like to speak, permit me first a few words in regard to our colleges. It is a pleasure to report advance along the entire line. The Hahnemann of Philadelphia led in the establishment of the three years' course of instruction as prerequisite to graduation, and now is among the first to advocate an increase in the term of study to four years. With this increase in the length of the course of studies, we are pleased to see a proportional increase in the facilities offered for the attainment of all useful knowledge in the various departments of medicine. This advance is more or less marked in all our colleges.

Next to this must be mentioned the increasing interest manifested throughout the profession in the development of our materia medica. For years past, owing to the vast bulk of material, various attempts have been made looking toward the condensation or abridgment of the materia medica. The controlling idea was manifestly that of simplification through abridgment alone; a condensation through the exclusion of symptoms which till then had failed to receive published corroboration—a plan at once both unscientific and unwise. To-day, while the need for condensation is equally felt, there is evidently a greater effort to reach the end desired through the hard beaten path of experience. Careful reprovings, aided by instruments of precision, are being instituted, and the utmost vigilance on the part of those conducting provings is being enjoined. The wisdom of Hahnemann's advice, to not entrust such important work to the unskilled observer, is being more fully recognized; and we have reason to believe that it will soon be as he desired, under the charge of those who are really "masters" in the art of observation. The work of correction, elucidation and verification, rather than destructive condensation, is now being earnestly encouraged.

In other departments we observe satisfactory evidence of ad-

vance. Especially is this noticeable in surgery. Though the past twenty years have witnessed some of the most brilliant achievements in this department, the current year has not failed to keep pace with its fore-runners. This is particularly true in the surgery of the brain and of the abdomen. Operations are constantly being performed and results attained which seem all but incredible.

In this field of work the subject of "antisepsis *vs.* asepsis" is attracting much attention, and from the latest results we are strongly inclined to the opinion that the old Hahnemannian view regarding asepsis is speedily being verified. Absolute cleanliness, in conjunction with Homœopathic medication, will, we have abundant reason to believe, accomplish all that dare be hoped for from the most stringent form of drug antisepsis.

A word in reference to our journal literature. Encouraging signs of prosperity are observable in most of our periodical publications. We are pleased to note that matters of real importance to the general practitioner, are receiving a more liberal share of space. In fact, there is a growing tendency to avoid useless polemics and devote more space to profitable discussions. Subjects of merely theoretical character receive abundant attention, yet not to the detriment of the practical. Materia medica and therapeutics are, in the main, receiving the consideration which their importance demands. Scientific inquiry has never been more zealously pursued, nor have the results ever been more satisfactory than during the past year.

The doubts and expressions of unbelief asserted so persistently by the Allopaths, have necessarily borne fruit among those not well grounded in a knowledge of the laws governing drug action. Like noxious seed they have often spread far beyond the fields where originally grown, and have caused sore trouble to many an honest reaper at the harvest. Nevertheless, even such open expressions of doubt may be welcomed, and may be employed to good purpose; they afford texts for thought, and thereby prompt researches which ultimately make plain nature's methods, and give a clearer insight into nature's laws.

While the spirit of *experiment and investigation* generated by such doubts ought to be encouraged, it must at the same time be cautiously guided. Intelligent research must lead to the accumu-

lation of useful facts. With the storing of facts comes a disposition to correlate and compare the same, and this, with the great facilities now at the command of almost every willing worker, must result in further elucidation of the grand and comprehensive principles so c'early taught by Hahnemann.

Pathology, that subject for such vexing disputes by ultraists in our school, is apparently approaching the border land of science, and we trust will soon possess a value far beyond what could have been anticipated even a few decades ago. Every assured fact has positive value; therefore we should welcome every authentic observation.

Beyond question the more thorough our knowledge of diseased processes, microscopic as well as macroscopic, the greater will be our opportunities to apply the law to their effectual cure. But just there is the rub. What is knowledge, and how shall we apply it unto wisdom?

A man may be versed in all the technical rules of a science, yet lack the practical wisdom necessary to the utilization thereof. "Ah!" said a learned professor to an illiterate waterman, "How sad that your life is so far spent, and you know naught of the wonders of nature's laws." Just then a huge wave swamped the boat, and the learned professor sank: "Of what use is your knowledge of the laws of nature, if you can't swim?" said the boatman, as he helped the hapless professor to land.

Here permit an application of this thought. Are not our colleges reaching the point at which too many technical studies are being crowded into the course of instruction requisite to graduation? Ought not more attention be given to the more practical branches; and should not the more distinctly technical studies be pursued in specially provided post-graduate classes? Adequate facilities for such a course should be furnished by every properly equipped college. Thus, physicians having the time and talent to master the details of laboratory technique, would find abundant opportunity to gratify their desires. The advantages of such a course are too palpable to require argument. The fundamental studies having been thoroughly mastered and the mind thereby prepared for the more abstruse problems, the student would possess the requisite qualifications for the theoretical work. Such

investigators would learn the importance of thoroughly training the powers of observation and the art of reasoning. By such a method many well trained observers and skilled investigators might be added to the profession.

The last year of college tuition should be devoted to those practical, though probably less attractive studies, which tend to make the really successful practitioner. The minutiæ involved in the actual attention upon the sick, differential diagnosis, the therapeutic treatment, the diet, hygiene, and the nursing requirements, all of which can only be mastered by daily study at the bedside of the patient, would afford enough scope for the entire last session of undergraduate studies; and thereby the student would be better fitted to go out and treat the sick. In fact, the last year should be devoted to walking the wards of the hospitals, and taking charge of the sick at their homes, under the guidance of competent instructors appointed by the faculty. In other words, give the student that homely knowledge which the older physician gained only through long service, as office student and assistant, under a thoughtful general practitioner of medicine, and you will make of him a valuable and beloved physician—not simply a graduate doctor of medicine, well stocked with book-lore, yet lacking the wisdom wherewith to apply it. The young practitioner would thus escape many sad and depressing days.

Let me not be misunderstood as intimating that the physician can have too much of even technical knowledge. Far from it. The most that he can acquire is still insufficient. If, however, our students must be graduated before they can possibly acquire sufficient practical and technical knowledge, which in fact would require more than a six-years' course, let them be prepared with that which is really essential to the successful treatment of the sick. The more abstruse technical studies may without detriment be deferred. The early years of post-graduate life afford ample time for study, and, to the real student are freighted with opportunity for research unhampered either by the anxieties of the under-graduate, or the responsibilities of a later and larger practice.

While it is sincerely to be desired that our young men profit by every opportunity for extended research in the various departments of medicine, we must nevertheless deprecate the unguided

experimentalism which until recent years has been the prevailing fashion in the older schools of medicine. Strict adherence to the systematic and logical methods inculcated by Hahnemann should be encouraged. Such methods have given us men like Hering, Jeanes, Dunham, Jahr, Bœnninghausen, and a host of masters in medicine, of whose names and work we may well be proud.

Much of that which masquerades as philosophy is really naught save a superficial form of mental divertisement, affording practice, but not progress. It it rather like the soldier in the act of marking time. There is expended the exertion of progression, there is a constant change in the point of support, yet never any advance. Such theoretical fancies are as the ungeared treadmill on the threshing floor, making much clatter, but accomplishing nothing.

The more recent investigations, especially those in reference to the relationship of micro-organisms to disease, have especial interest to us as Homœopaths. The experiments of Koch confirm to a marked degree the earlier experiments of Hering and others of our school, who, more than sixty years ago, began a series of investigations in relation to the action of the so-called nosodes, psorinum, anthracin, lyssin, and later the tuberculinum, etc., which have since rendered most efficient service in the treatment of disease. Beyond doubt these remedies would have received more general attention had not prejudice been aroused against their use. The faulty position taken by our Allopathic investigators must needs be followed by disappointment. Generalization is the keynote to their whole idea. Ultimately, however, when they acquire a correct conception of the sphere of action of the nosodes, if their disappointments do not deter them from further study, we will have the satisfaction of seeing the early views of Hering and other investigators of our school confirmed. *Individualization*, based upon the real correspondence between the symptoms of the provers and patients, is the only true guide to the selection of the curative remedy.

Many of the theories more recently advanced in explanation of the action of these preparations are apparently replete with wisdom. They remind one, however, of the "ox of Prometheus" Under superficial observation they seem to possess value; *careful* investigation proves them to be but worthless fancies.

While then we would urge upon the members of the profession the importance of continued interest in the study of the nosodes; yea, in every effort to advance the line of the known, we would at the same time *caution them* against that false philosophy which is retarding the acceptance of the principles involved in the "law of similars," as *embodying the principles underlying the therapeutic law of cure.*

When we contemplate the progress in medicine during more recent times, we find abundant cause for encouragement. The growing disposition in the old school to acknowledge the principle of similars as a rule in practice, is especially worthy of note. The manifest inclination to investigate the action of infinitesimal doses is another marked evidence of advance. In illustration of this latter the experiments of Prof. Stilling, published in Merck's *Bulletin*, October, 1890, are well worthy of mention. Prof. Stilling, in his second report on pyoktanin, says: "Comparative series of experiments which I have made showed that sublimate in the proportion of 1 to 2,000,000 of the nutritive fluid, wholly arrests the development of the pus-cocci. I also made trials with agar cultures, using sublimate and pyoktanin in two parallel series, in proportions running from 1 to 1000 to 1 to 128,000. In these cultures, both drugs showed the same degree of power in impeding the development of cocci. Solutions of 1 to 1000, to 1 to 2000 arrest the development completely." Pyoktanin, we must remember, is reputed innocuous. Prof. Stilling asserts, "pyoktanin may be considered as absolutely non-toxic for external applications." The professor deduces from Ehrlich's experiments on alizarine, that the calculated quantity of pyoktanin which might be dusted on or into a wound in a human patient without detriment amounts to at least 50 grammes, "an immense quantity, which would never be even approximately required in actual practice."

Another, by no means unimportant change in Allopathic practice, is found in the evident desire to avoid polypharmacy as being less scientific and less reliable than the single remedy. Thus as water finally wears away the rock, so too is the truth given us by Hahnemann gradually wearing away the flinty barrier of prejudice and unbelief which bigotry set up in the path of progress nearly a century ago.

The three grand points of support upon which Homœopathy was founded, viz., "the law of similars," "the single remedy," and "the minimum dose," are receiving recognition in the school of our opponents. We look hopefully forward to the day when they not only almost, but altogether, will believe.

Another subject worthy our careful consideration is that of our hospitals. Private charity has in this State given us, within the past few years, several excellently equipped institutions, of which we cannot speak too highly. These hospitals being supported almost exclusively by private contributions, we regret to say are taxed to their utmost to supply the wants of those applying for treatment. The State, though dealing with lavish hand when making its apportionments to the various Allopathic hospitals, has dealt most grudgingly in the appropriations to institutions in which the Homœopathic method of treatment is employed. This certainly is not just, and it is our duty to earnestly strive for its correction. United action on the part of the adherents of Homœopathy will doubtless correct this in the near future. Again, I desire to call your attention to those institutions known as "State Hospitals." This is a subject of more than passing interest to every advocate of Homœopathy. At present there is every prospect of the establishment of another State hospital for the treatment of the insane, which, in the ordinary course of State patronage, would fall into the hands of the Allopaths. This, then, is a most opportune time to make known our position in reference to the continuation of a system of control which practically results in the establishment of "a State medicine," diametrically opposed to the best interests of hundreds of thousands of Homœopathic patients residing within this Commonwealth.

Already the Allopaths hold full control over no less than five large hospitals devoted to the treatment of the insane, one at Harrisburg, with 781 patients; one at Danville, with 967 patients; one at Norristown, with 1911 patients; one at Warren, with 779 patients; one at Dixmont, with 733 patients; making a total of 5171 patients, which during the past year were in institutions under Allopathic control exclusively. In addition to the foregoing there were, on September 30, 1890, not less than 1585 insane distributed among seventeen different almshouses located in various parts of

the State, thus making in all, twenty-two institutions receiving patients suffering from mental diseases; in none of which can our patients, rich or poor, secure wished for treatment. In other words, the State practically refuses to grant to the Homœopathic insane an acceptable method of treatment. This, too, in the face of the fact, as stated by the Board of Public Charities in their last annual report, that "the meagre results of the treatment of insanity are unquestionably a reproach to modern medicine, while the very small percentage of recoveries on the total number treated has so strongly emphasized this fact that public economists declare against the future expenditure of appropriations for rearing and appointing costly structures which are hospitals merely in name; but which are in fact asylums mainly for the detention of the chronic and incurable." And again, "if the State hospitals are expected to do the greatest good to the largest number, there must be thorough special individual treatment of acute and improvable cases, in hospital buildings especially equipped for that purpose, totally apart from the hopelessly chronic."

"No general hospital for the treatment of physical diseases could long survive if conducted upon the plan which is considered good enough for the insane; but insanity will no more yield to routine and perfunctory treatment than would pneumonia or dysentery."

The deplorable condition of our insane revealed in this statement makes the question especially pertinent: Has the State a legal right to withhold from so large a proportion of its citizens the treatment of their choice—a treatment, which, under all circumstances, requires the individualization, which they, *at last*, perceive to be necessary?

This query assumes quite a different aspect from that which it presented a few years ago. Our school has outgrown the merely experimental stage. Based upon an unchangeable law of nature we may rest assured of its permanency. Is it not, then, a palpable usurpation of power for the political authorities of a State to arbitrarily determine the school of medicine of which its hospital practitioners shall be adherents, thereby excluding all other recognized and established systems from *State* recognition? Should not the State permit a treatment in accordance with the wishes of patient and family, and, in fact, provide the treatment desired, es-

pecially when such treatment is in accordance with the views of so large a body of its citizens?

We have forced from the unwilling lips of teachers in the dominant school the admission that the principle of similars stands side by side with the principle of *contraria*. We have a clientele equal intellectually and financially to that of any school of medicine. Nevertheless, to-day we hold the anomalous position in this Commonwealth of more than a million of people bearing their full share of taxation yet without representation in a matter involving the care of both body and mind when in a state of disease.

The Allopathic school receives not only State recognition, but is accorded the monopoly of our State medical institutions. Have we any moral right longer to continue in quiet submission to such palpable injustice to our patients? They trustfully look to us for help. We have our organized societies, and our patients rightfully feel that through them their interests should be protected. To longer continue in such apathetic inactivity would be most censurable. We cannot make reasonable excuse therefor. It is our bounden duty to champion our patients' cause. Prompt and effective action should be taken at this meeting of our State Society. We should appoint a special committee authorized to employ all lawful means to secure that which our patients have a just right to demand, viz., just representation in the State charities. Action is especially necessary at present, in that the Legislature has authorized additional hospital accommodation for the care of the insane. In the event of the erection of another State hospital, it should be devoted to the treatment of those suffering from acute mental diseases, and placed under the care of Homœopathic physicians. One of the older buildings should be devoted to the chronic and incurable insane. This would be but an act of justice, one which our Legislature would no doubt willingly accord.

Legislation in reference to the licensing of physicians is another and equally important matter to which our attention should be directed. Underlying it there is undeniably the desire of the Allopaths to secure control of the licensing power, a dictatorship which would seriously impede our progress and practically close the doors of our colleges, as with Allopathic control of the licensing power, students would quite naturally seek to secure the de-

gree in medicine from some Allopathic college, in order thus to remove one possibly serious obstacle to their entrance upon practice.

Some of our members may think this an extreme view, but in prospect of the creation of an Allopathic board, the suggestion was made to at least one of our students during the past spring that it would be wise for him to matriculate in an Allopathic institution, as by the time he graduated the licensing power would be virtually under the control of the Allopaths, and his prospects necessarily in jeopardy if he held a diploma from a Homœopathic college. Nay, do not think this causeless alarm; I assure you it is but timely warning.

The Philadelphia County Society has already taken active measures looking to the organization of district societies for the purpose of protecting the Homœopathic school against the machinations of its enemies. I trust that the Committee on Organization will institute similar measures throughout the State, in order that every county may be duly represented. Thus, and thus only, can we meet the organized opposition of the Allopathic school.

In 1885 a movement was set on foot in the American Medical Association looking toward State control over the licensing of physicians throughout the country. This, as a principle, is sound, and should be heartily approved by every physician and layman in the land. The only difficulty lies in the manner of attaining the end, especially with regard to the methods employed for the accomplishment thereof.

Governmental supervision is distinctly called for in every field of life in which man, in his individual or in his congregate capacity, comes into social, professional or business relationship with his fellow-man; therefore the physician, and with him the colleges, are within the legitimate field of such control; for certainly none hold more responsible relationship than that which the physician bears to patient, family and State. But what shall this supervision be, how far shall it extend, and by what principles shall it be guided and governed? These are questions of deep import, yet may be briefly answered as follows: First, such supervision should extend over the classical as well as over the medical edu-

cation of the student prior to his graduation. Secondly, the colleges should be more directly under State supervision. Thirdly, all laws looking toward this end should be based upon the most unequivocal principles of justice and equity.

Beyond question the colleges are, and always have been, directly under the control of the State. From the State they receive power, and are commissioned to perform certain duties. An honest fulfilment of these obligations must then be recognized by the State as righteous conduct, and the rights and privileges granted by the State remain, or should remain, unimpaired. In failure to fulfil the obligations assumed by the college under its charter, the franchises of the college are forfeited to the State and the charter is annulled.

It is both the right and the duty of the State to assume and maintain full power over her educational institutions. Failure to exercise the same would be grossly reprehensible, in that it practically would invite most pernicious imposition and fraud.

In addition to this, however, the State has another and quite specific duty to the individual. It guarantees to the individual perfect freedom of thought and action in all personal matters, and leaves his philosophy, as well as his religion, untrammeled by legislative enactments. He is constituted by the State a free agent, to do, or not to do, as he wills, so long as he neither hinders nor deters others in the free exercise of their lawful rights. This being guaranteed by the State, and necessary to the genius of American legislation, dare we, as a matter of principle, abandon the same? Nay, we must earnestly strive to maintain our rights, and the rights of our patients, not from any selfish motive, as desire for power, but in full recognition of the fact that every right is inseparably bound to some given duty. The responsibility rests upon us as physicians, and especially as Homœopathic physicians, to secure to ourselves and our patients that immunity from oppression which is guaranteed to us by the laws of this Commonwealth. Remembering that a right neglected is duty undone, let it never be said of us that we have been faithless to either; the one must be maintained in order that the other may be faithfully performed.

But, gentlemen, the cry for examining boards has gone up from

the ranks of the Allopaths; they see in them a new source of power; one more, even if forlorn hope, to which their souls may cling. They call lustily upon the people for more power wherewith to purge the profession of all incompetents. They desire that these boards shall be composed of Allopathic practitioners, and demand that we passively submit to their dictum. Woe unto the school that shall come under the iron heel of their prejudice.

This whole matter of State examination in medicine is fraught with danger to the medical profession, and stands as a menace to the best interests of the laity. Evidence of this fact may be found in the more recent workings of such boards. One of the strongest advocates of State boards of medical examiners says, in a recent number of the *University Medical Magazine:* "State medical examining boards must exert great influence upon teaching faculties, and there always is danger that medical schools shall prepare men for examining boards rather than for practice of medicine." The same writer, referring to a recent examination, remarks: "If this examination is to be the type, one of two things must happen—thoroughly trained graduates of medical schools of the first class must fail altogether, or at least go to the bottom of the list, or else medical colleges will have to strive to make mediæval lumber-attics of the heads of their students, much to the disgrace of American medicine and the detriment of American communities." Such are some of the early fruits of this still recent Allopathic reform. Dare we trust our interests to such incompetent boards?

While I am fully convinced that the whole scheme is erroneous, beginning in fact at the wrong end of the problem, I am equally convinced that if such laws are to be enacted, and we are to obtain justice, it must come through the creation of separate boards. If the Governor can find honest and honorable men in the one school, he certainly can find them in the other. To intimate otherwise is a slander upon the profession. Therefore, if the Allopaths are seeking, as they claim, the protection of the people, they can secure it equally well through separate boards, and should give the same their support. In failure of which they give unmistakable evidence of their desire to act to the prejudice of our school, thus exposing themselves to the charge of insincerity and fraud. Let us hope that better judgment may prevail in their councils; that

the spirit of liberality so marked in every other department of science may extend its beneficent work to that of medicine. Then, and only then, can we hope that *law* will take the place of conjecture, and that experimental research, based upon law, shall entirely supplant mere theorizing and dogmatic assertion.

I will close this subject with the following extract from remarks made before the joint Judiciary General and Health Committee at Harrisburg last winter: "The existence of a board of examiners and licensers practically under the control of the self-styled regulars should be persistently opposed, because, first, the Homœopathic school has for years been in the forefront of progress and deserves in this movement full recognition by the State. Secondly, such control of the licensing power by our opponents would stand as a constant menace to our school; on the one hand through unjust discrimination, and on the other by leading many students to seek, for prudential reasons, their degree in medicine from colleges in affiliation with the majority of the board. Thirdly, by granting such power to the dominant school the laity would naturally infer that the State regarded the Homœopathic school as deficient in educational requirements, thus lending color to the false accusations of our opponents. Fourthly, the granting of such power must be viewed as but an entering wedge directed toward still further restrictive legislation. Fifthly, such *unjust restrictive measures* are diametrically opposed to the genius of American thought and principle, and can only retard progress in medicine as they would if applied to any other department of science."

And now, in closing, permit me to thank you for the honor which you have conferred upon me in electing me your presiding officer this year. With your help we will endeavor to so expedite the business of our sessions as to render our meeting a source of both pleasure and profit to all.

On motion, the address was received, with the thanks of the Society to the author, and referred for action to a committee of five members, consisting of Drs. C. C. Rinehart, of Pittsburgh, Chairman, Joseph E. Jones, of West Chester, C. A. Yocum, of Pottstown, A. P. Bowie, of Uniontown, and W. J. Martin, of Pittsburgh.

On motion, roll call was dispensed with.

Dr. J. F. Cooper, of Allegheny, then presented the annual report of the Treasurer, as follows:

REPORT OF THE TREASURER.

Balance due the Treasurer at last report,		$352 30	
1890.			
Sept. 17.	Paid bill of W. E. Hering,	10 50	
" "	" " " H. Brooks, .	3 25	
" 19.	" " " E. R. Snader, .	28 53	
" "	" " " E. W. Eckel, .	46 10	
1891.			
Jan. 21.	Paid bill of E. W. Eckel, .	9 50	
Feb. 20.	" " " Sherman & Co.,	443 95	
Aug. 17.	" " " E. W. Eckel, .	9 00	
			$903 13
Sept. 15.	Received since last report, dues of members, . . .	$763 00	
" "	Received since last report, assessment of 1888, . .	12 00	
" "	Received since last report, sundry sources, . . .	13 00	
" "	Balance due the Treasurer,	115 13	
			$903 13

Respectfully submitted,

J. F. Cooper, M.D.,
Treasurer.

This report was accepted and referred to an Auditing Committee, consisting of Drs. E. C. Parsons and Joseph E. Jones.

This committee during the succeeding session made the following report:

Pittsburgh, Pa., September 16, 1891.

We, the undersigned committee, appointed to audit the account of our Treasurer, respectfully report that they have examined the books and compared the vouchers and find them correct, the Society owing our Treasurer $142.13.

E. C. Parsons, M.D.,
J. E. Jones, M.D.,
Committee.

The Corresponding Secretary then made his report as follows:

REPORT OF THE CORRESPONDING SECRETARY.

A complaint has been made by quite a number of members when the Secretary has written them regarding the titles of bureau papers, that they were not aware that they were members until they received my request for their titles. Your Secretary wishes to report that all gentlemen appointed on bureaus are officially notified of their appointment to bureau work. In other words, the fact of the receival of the notification drops from the memory, and even the Secretary's reference to neglected duty does not revive recollection. Your Secretary makes it a special point to see that such notifications are sent, and they are sufficiently explicit.

Your Secretary would request that his communications to members be answered. Sometimes, when information is required, none is given, and consequently delay is caused in the publication of the programme announcing the proceedings.

Respectfully submitted,

E. R. Snader, M.D.

On motion, the report of the Corresponding Secretary was accepted and referred for action to the Committee on President's Address.

John C. Sanders, M.D., presented his credentials as delegate from the Homœopathic Hospital College, of Cleveland, Ohio, with which institution he has so long and honorably been connected as Professor of Obstetrics. On motion, the professor's credentials were accepted, and he was cordially invited to accept the privileges of the floor.

Dr. R. B. Rusk, of Salem, Ohio, was introduced and unanimously accorded similar privileges.

Dr. E. R. Snader, for the Committee on Publication, made the following report:

REPORT OF THE COMMITTEE ON PUBLICATION.

Your Committee reports that four hundred copies of the *Transactions* were printed, of which a certain number have been distributed to members, and the remainder are in the possession of the Society. The figures regarding the cost of publication will be given you in the Treasurer's report.

The *Transactions* of 1889 show 320 printed pages, against 286

pages in the issue for 1890, making a discrepancy between the two volumes of 44 pages. There is, however, in the *Transactions* of 1890 quite as much reading matter as in those of 1889. The volume of 1890 is not so bulky, not so well appearing as that of the preceding year. The cause of this decrease in size resulted from an effort on the part of your Secretary to lessen the cost of composition on the *Transactions*. In order to do this the lines were widened somewhat, and a type employed that would "take in" more letters than the type employed for the *Transactions* of the previous year. Some of the type was also borrowed from the *Hahnemannian Monthly*. Had all the papers read by title been placed in the hands of the editor of the *Transactions* the 1890 volume would have been of greater size than that for the year 1889. However, these were not forthcoming. In addition, other papers were handed the Secretary in such an irregular manner that certain portions of the volume were composed and printed before the papers were placed in the hands of the editor. It was, consequently, impossible to estimate the amount of material at a date sufficiently early to avoid the cost of reprinting the volume. Your Corresponding Secretary holds the other members of the Publication Committee blameless for the appearance of the volume. Your Secretary confesses to an error of judgment; but the error consisted, not in the attempt to reduce the cost of publication, but in imagining that all the literary material promised him would be available for the purpose of increasing the size of the volume. It was the intention of your committee to give you more reading matter than in 1889 at the same cost. The result of this intention is that you have as much reading material as in 1889, but a volume decreased in size, and, in general, not so handsome in appearance as that of the two preceding years.

Your committee must insist, in the interest of the early issue of the *Transactions*, that all papers read before the Society, shall be placed in the hands of the Corresponding Secretary immediately after being read. All documents and committee reports should also be placed in the Secretary's hands.

Respectfully submitted,

E. R. Snader, M.D.,
J. Richey Horner, M.D.,
J. F. Cooper, M.D.

The Committee on Medical Legislation and State Regulation of Medicine made their report as follows:

To the Homœopathic Medical Society of Pennsylvania:

Your Committee on Legislation and State Regulation of Medicine, appointed last year, and instructed to prepare a bill upon medical education, and secure, if possible, its enactment by the Legislature of the State, would respectfully report as follows:

That, immediately upon the adjournment of the Society, its members came together and organized by electing a chairman and a secretary and the appointment of a sub-committee to prepare a bill in accordance with the instructions of the Society.

After due deliberation by the members living in Philadelphia and correspondence with the other members, this bill was formulated and printed. Early in the session it was presented through Hon. W. H. Brooks to the Legislature and strongly urged upon their attention. It seemed to meet with a hearty approval, as being the best means of benefiting the people, yet in consequence of the strong division of sentiment among the different schools of medical practice upon medical legislation, it, together with the "Medical Examiners' Bill," failed to pass.

1. Your committee found the Legislature ready to enact laws governing the practice of medicine whenever a bill can be presented that will meet the approval of the various schools, or one that they may think will not be a decided injury to either school.

2. We were met by a perfectly organized body of physicians, in which every county of the State having an Allopathic medical society had its due representation, through which organization every member of the Legislature was waited upon at his own home and strongly importuned to favor the bill and at the same time filled with the usual "cant" against our system.

3. That our own school was not only not organized, but we were not harmonious upon the bill presented. Some were opposed to it, more were in favor of a "three-board examiner's bill," more still were entirely indifferent to any kind of medical legislation, as it was not likely to affect them personally. Such conditions again existing, we may certainly look for an overwhelming defeat.

The fight this year was, in consequence of the above circum-

stances, a hard and persistent one, and, thanks to fair-minded legislators, successful for us. By reason of its position upon the calendar the "Examiners' Bill" was made the battle-ground. We met it squarely, and by reason of adding amendments which seemed both right and just to the honorable members, the bill, when it came up for final passage, was defeated at the request of its own backers, while your committee sat as interested witnesses.

Your committee would most earnestly urge the Society to give this subject its special attention at the present session. Nothing so vitally important to the profession can be presented for your deliberation.

We would respectfully urge:

1. A thorough discussion of the subject, and, if possible, unanimously settle the line of action for the future. Whether it shall be a three-board examiners bill as a matter of policy, an examiners' bill with equal representation, an educational bill, or no bill at all, let the Society speak emphatically its mind at once, for our opponents are already organized and united.

2. We would strongly urge some plan for an immediate and thorough organization of the Homœopathic physicians and friends in every legislative district in the State. We met *many* members, and some of them patients and personal friends of Homœopathic physicians, who had not heard a word from any one either in favor of our cause or against the Allopath's bill, but not a member but had been personally seen or written to by almost every Old-School doctor in his district endeavoring to secure his pledge to support their bill.

3. The necessary attendance of so many members of your committee as frequently as was needed last year entailed so much expense and loss of time and business that some other means should be adopted. We would suggest that your committee be given the authority to employ an agent who can be constantly on hand and can notify the committee when it is needed to be present at the seat of legislation. Said agent should not be a member of the Legislature.

4. Some means should be devised for securing a fund with which to meet the necessary and legitimate expenses of this work.

5. After the Society has fixed upon a definite course of pro-

cedure, an energetic chairman with an active committee, all of whom should be enthusiastically in accord with the action of the Society, should be selected and the Society pledge itself to a cheerful and persistent co-operation with its committee in the prosecution of this all important work.

Respectfully submitted,

JOHN E. JAMES, M.D.,
Chairman.

DISCUSSION.

DR. E. C. PARSONS: We would like to hear from Dr. Korndœrfer. He was on the battle-field, and can tell us all about the fight.

DR. Z. T. MILLER: It is better to know what we are going to do than what has been done.

DR. E. C. PARSONS: We will better understand what to do if we hear what was done at Harrisburg.

DR. C. P. SEIP: How was the fight carried on? We want to know how to fight.

DR. KORNDŒRFER: I regret that Dr. John E. James is not with us to-day to make report of the work done by the Legislative Committee during the past winter. As chairman of that committee he was untiring in his efforts to secure a successful issue. The committee were confronted on their first visit to Harrisburg by the fact that our bill had been referred to the Health Committee instead of to the Judiciary General, as was expected. The Health Committee being largely composed of Allopathic physicians, you can readily understand that our bill would receive but scant favor. However, after a hearing, we secured a reference of our bill, together with the Allopathic bill, to the joint "Judiciary General and Health Committee." On appearing before this joint committee we were confronted by a delegation of nearly a hundred Allopathic physicians, representing all sections of the State. Through the efforts of the member of the House having charge of the Allopathic bill, they secured the floor, and had it not been for the earnest efforts of your committee our side would have scarcely been heard. After they had held the floor about one hour, one of your committee was permitted to speak. Though frequently interrupted by questions from the Allopaths, we finally were enabled

to make plain the position which we, as a school, maintain in regard to the subject of State control in medicine, viz., that such supervision should be over the educational institutions of the State rather than merely over the licensing of physicians. The argument offered by your committee bore fruit in a favorable report from the joint committee. This report, however, was largely offset by a similar recommendation for the Allopathic bill. The Allopathic bill being given priority on the calendar, the contest necessarily centered on the "Medical Examiners' and Licensers'" bill. After the first reading of this bill in the House, they thought it desirable to start a similar bill in the Senate, consequently Senate Bill No. 258 was introduced March 24th. This was amended, and passed second reading two days later. As amended, the bill excluded both materia medica and therapeutics. It, however, provided for an examination in the practice of medicine. Another amendment struck out the proviso, "That any candidate for examination may elect the system of materia medica and therapeutics in which he or she shall be examined." Thus, while the student was apparently relieved of examination in two studies, the law really made it possible for the board to examine all applicants upon the therapeutics of disease, and consequently indirectly upon materia medica under the branch practice of medicine. At the same time the act precluded the applicant from electing the system under which he should be examined. This little scheme was frustrated, and, on the third reading, we secured amendments which led the Allopaths to desire the defeat of the bill. After further contest in the House the bill was brought to a vote during the last hours of the session and received an overwhelming defeat. Thus was brought to a close the contest of '91.

Dr. Willard: Hearing this report we feel that we have been remiss in our duties. False reports came from Harrisburg. We were deceived by a declaration that the bill was dead, and hence the Western men remained away. I am in favor of no bill, or a board of medical supervisors who shall have the control of all college arrangements. I am opposed also to an educational bill. There will be another fight next session. They cannot succeed, however, in defeating us if we demand only equal representation.

Dr. Korndœrfer: Other States have passed separate board

bills. The conference committee scheme nearly defeated us despite the intention of fair-minded members.

Dr. Willard: If they will have legislation, let us confer with the Allopaths and settle the matter before the meeting of the Legislature.

The Committee on Treasury reported that there was still a deficit in the accounts; that the Society was still in the debt of Dr. Cooper to a considerable amount. It was not deemed expedient to make any assessment on the members of the Society, and by motion it was finally resolved to endeavor to liquidate the debt by raising a subscription. It was decided to do this by committee, and Drs. J. F. Cooper, Bushrod W. James, and J. R. Horner were appointed that committee, with instructions to report at the next meeting of the Society.

Dr. Millie J. Chapman, delegate to the Southern Homœopathic Medical Association, reported as follows:

Mr. President and Members:

Last November I attended the Southern Homœopathic Medical Association at Birmingham, Alabama. About a hundred persons were in attendance, and many able papers were presented. The entire three-day session was full of interest. The members are earnest, capable men and woman, well qualified and thoroughly in earnest in their battle for Homœopathy. The meeting was well reported in the daily papers, creating much interest among the citizens. Some of the best people of the place attended not only the public meeting given, but also the session when the Legislative Committee reported. So strong has been the restriction of the old-school officials that, until this meeting only thirteen Homœopaths were practicing in the whole State of Alabama. Six more have located within her borders, and at that session a State Society of nineteen members was organized. These, with the Legislative Committee of the Association, by their aggressive efforts have so far defeated the dominant school in their attempts to prohibit the practice of Homœopathy. A very full report of the work of the Committee on Medical Legislation in that State has been published in the *Southern Journal of Homœopathy.*

Dr. Korndœrfer reported for the American Institute of Homœopathy and the International Homœopathic Congress a meeting successful beyond the most sanguine expectations both as regards its scientific quality and the great number of members and delegates in attendance. A number of foreign delegates were there, and these, with the great number of physicians from our own country, contributed to make a gathering which will long be remembered as one of the grandest ever known in medical history.

Dr. J. R. Horner, Chairman of the Bureau of Organization, Registration and Statistics, made his report as follows:

REPORT OF THE BUREAU OF ORGANIZATION, REGISTRATION AND STATISTICS.

The report with tabulated statistics is herewith appended. (See page 36.)

In the matter of hospitals we are gratified to be able to announce the opening, July 1, 1891, at Reading, of a Homœopathic Hospital. This fills a long felt want there, and our Reading friends are deserving of the highest praise for the accomplishment of the result. The building devoted to the work is a fine three-story structure, with a large lot at the side, and is located in the heart of the city. The interior of the building has been so arranged as to make it very suitable for its purpose. At the opening exercises a very large audience was present and much enthusiasm was manifested.

Another institution which has come under the control of Homœopathy is the new Home for Widows and Orphans of Odd Fellows situated in a suburb of Allegheny. Of this we hope to report good results later on.

The new Hahnemann Hospital at Philadelphia has been opened since our last report with the results noted in the table. Of this institution little need be said. It stands second to none in its appointments, and is in charge of men whose good work in the past may be taken as a guarantee of the future. Philadelphia is certainly to be congratulated.

Of the Germantown Dispensary we could get no report whatever, and it is in consequence omitted entirely from the statistics.

The statistics are not yet perfect, but we hope to present next

year a more complete and satisfactory showing. Of the showing itself we are proud, as the figures here, as all such figures do, show a decided balance in favor of our methods and systems of treatment.

An addition to the report of last year is the report of publications of journals published in the State. This shows the issuing of four journals with a total of twenty-four hundred pages of reading matter each year. This is a matter of congratulation, as the journals have an exceedingly large circulation. Not the least in influence, though the smallest in number of pages yearly, is the *Homœopathic Envoy*. This should be given a wide circulation by physicians. Much good would be accomplished if the members of the Society would subscribe for a number of copies—ten to twenty-five—and have them sent where they would be read and circulated more freely. The cost is but trifling—only twenty-five cents per copy per year, and the good which must necessarily result would fully repay an even larger outlay.

Another addition is the reports of societies. These show a very healthy condition throughout the State, but there ought to be more. Wherever three or four or more physicians are practicing near each other, they should organize for study. The benefit would be mutual.

Respectfully submitted,

J. Richey Horner, M.D.,
Chairman,

Edward R. Snader, M.D.,

J. F. Cooper, M.D.

HOMŒOPATHIC MEDICAL SOCIETIES

Name.	President.	Secretary.
Lehigh Valley Hom. Med. Society.	E. H. Jackson, Bethlehem.	E. D. Doolittle, Easton.
Philadelphia Clinical Club	C. M. Thomas, 1623 Arch St., Philadelphia.	W. H. Bigler, 118 N. 12th St., Philadelphia.
Hom. Medical Society of Northern Pa.	H. B. Ware, Scranton.	T. M. Johnston, Pittston.
Hom. Medical Society of Erie County.	R. T. Marks, Erie.	J. F. Flint, Erie.
Bœnnighausen Med. Club of Philadelphia.	D. Macfarlan, 3924 Chestnut St., Philadelphia.	G. W. Smith, 1320 Walnut St., Philadelphia.
Hom. Medical Society of Beaver County.	J. S. Boyd, New Brighton.	Wm. Raynor, 1400 Sixth Ave., Beaver Falls.
Hom. Medical Society of 23d Ward, Phila.	J. R. Osman, Bristol.	S. G. Godshall, Edge Hill.
Hahnemann Club of Phila.	M. M. Walker, 12 W. Walnut Lane, Germant'n.	T. S. Dunning, 1328 N. 15th St., Philadelphia.
Hom. Medical Society of Crawford County.	E. C. Parsons, Meadville.	.....
Organon Medical Club of Chester.	R. P. Mercer, 223 W. 3d St., Chester.	D. P. Maddux, 700 Madison St., Chester.
Hahnemann Med. Soc. of Reading.	J. S. Rittenhouse, Reading	C. B. Jennings, 137 S. 8th St., Reading.
Schuylkill County Hom. Medical Society.	L. A. Snyder, Ashland.	E. L. Straub, Minersville.
Allegheny County Hom. Medical Society.	C. H. Hoffman, Pittsb'gh.	C. A. Wilson, 295 Western Ave., Allegheny.
Alumni Assoc'n of Hahn. Med. Col. of Phila.	J. P. Dake, Nashville, Tenn.	W. W. Van Baun, Phila.
Hom. Med. Soc. of Chester, Delaware and Montgomery Counties.	W. C. Powell, Bryn Mawr.	Horace Sill, Norristown.
Hom. Medical Society of Philadelphia Co.	W. H. Keim, Phila.	W. W. Van Baun, Phila.
Hom. Pharmaceutical Association of Phila.	A. J. Tafel, Phila.	F. J. Slough, Allentown.
Farrington Materia Med. Club of Allegheny Co.	W. F. Edmundson, Pittsburgh.	W. Cowley, 6412 Penn Av. Pittsburgh.
Phila. Medical Club.	O. S. Haines, Phila.	E. M. Mercer, 157 N. 13th St., Philadelphia.
Hom. Medical Club of Germantown.	J. H. Closson, Germant'n.	Thos. Reading, Hatboro.
Hahnemann Clinical Club of Philadelphia.	L. W. Thompson, Phila.	I. G. Shalcross, 1631 Arch St., Philadelphia.

OF THE STATE OF PENNSYLVANIA.

When Organized.	When Incorporated.	When Meetings are held.	Where Meetings are held.	No. Members.	No Admitted Last Year.	No. Deceased Last Year.	Annual Dues.	Publications.	DELEGATE.
1881	Not.	Bi-M'thly.	Members' Residences.	24	2	0	$1.00	Papers	.....
1880	"	Semi-M'ly.	"	10	0	0	1.00	"	.....
1882	"	Bi-M'thly.	W'es-Barre Scranton.	23	5	0	2.00	"	.....
1891	"	Quarterly.	.....	12	.....	.....	Orga Apl.1	nized 1891.	Ed. Cranch.
1877	"	Monthly.	Residence of Sec'y.	9	0	0	6.00	...	.....
1883	"	Quarterly.	"	9	0	0	...	...	.....
1881	"	Monthly.	"	22	2	1	1.50	...	Chandler Weaver.
1873	"	"	"	11	0	0	00	...	.....
1883	"	Quarterly.	Meadville.	14	0	0	1.00	...	E. C. Parsons.
1887	"	Monthly.	Residences of Memb'rs	9	2	0	...	...	R. P. Mercer.
1882	"	"	"	13	3	0	.50	...	.....
1883	"	Quarterly.	"	19	2	0	1.00	...	.....
1864	"	Monthly.	Pittsburgh.	50	3	1	2.00	...	C. C. Rinehart.
1884	"	Annually.	Phila.	729	70	10	00	...	J. P. Dake.
1858	"	Bi-M'thly.	"	27	2	0	1.00		J. E. Jones.
1866	"	Monthly.	"	200	20	5	1.00	...	W. H. Keim.
1881	1881	Annually.	"	10	0	0	00	...	F. J. Slough.
1887	Not.	Monthly.	Pittsburgh.	9	1	0	00	...	.....
1881	"	"	Phila.	12	0	0	00	...	O. S. Haines.
1877	"	"	Members' residences.	26	5	1	00	...	C. VanArtsdalen, C. V. Vischer, Thos. Reading.
1888	"	"	"	13	1	0	1.00	...	E. R. Snader.

HOMŒOPATHIC HOSPITALS AND INFIRMARIES

Name.	Location.	Executive Officer.	When Incorporated.	When opened to Patients.
Benedictine Infirmary.	Erie.	Mother Prioress.	Not.	1865
Hahnemann Hospital.	Phila.	W. C. Hannis, 526 Drexel Bldg., Phila.	1850	1852
Children's Homœopathic Hosp.	Phila.	N. B. Kelly, 8 Walnut St., Phila.	1877	1877
Medical, Surgical, and Maternity Hospital of Women's Hom. Association.	Phila.	Mrs. F. B. Skinner, P. O. Box 765, Phila.	1882	1884
Homœopathic Medical and Surgical Hospital.	Pittsb'gh	J. H. McClelland, Pittsburgh.	1866	1866
Boarding Home for Boys.	Alleg'ny	Mrs. M. A. Small, Alleg'ny.	1886	1877
Christian Home for Women.	"	Mrs. Thos. Scoles, "	1872	1872
Home for Aged Poor.	"	.....	1878	1872
Home for Aged Poor.	Pittsb'gh	.....	Not.	1884
Protestant Home for Incurables.	"	.....	1883	1885
Homœopathic Hospital.	Reading.	C. H. Ruhl, Reading.	1890	1891
Home for Colored Orphans.	Alleg'ny	Mrs. O. Phillips, Ridge Ave., Allegheny.	1879	1879
Home for Widows and Orphans of Odd Fellows.	Pittsb'gh	John A. Myler, Pittsburgh.	1890	1891

HOMŒOPATHIC DISPENSARIES

Name.	Location and Name of Executive Officer.
Hahnemann Hospital Dispensary of Philadelphia.	W. C. Hannis, 526 Drexel Building, Philadelphia.
Germantown Homœopathic Dispensary.	J. H. Closson, M.D., 70 W. Chelten Ave, Germantown, Philadelphia.
Pittsburgh Homœopathic Dispensary.	Geo. L. McCoy, Pittsburgh.
Children's Homœopathic Hospital Dispensary.	N. B. Kelly, 8 Walnut Street, Philadelphia.
Dispensary of the Women's Homœopathic Hospital Association of Phila.	Mrs. F. B. Skinner, P. O. Box 765, Philadelphia.

OF THE STATE OF PENNSYLVANIA.

No. of Beds.	No. Patients treated last year.	Cured.	Relieved.	Not Relieved.	Died.	Estimated value of Hospital and Grounds.	Amount of Productive Property.	Sources of Income.	Delegate.
10	60	49	11	0	0	.....	.....	.....	E. Cranch.
125	585	382	79	18	27	$506,290	$150,491	Col'ge Fees, Investments, Donations, Board of Patients.	C. Mohr.
55	109	66	22	...	5	75,000	.....	Donations.	B. W. James.
64	296	202	72	9	13	174,000	66,000	Board of Patients.	B. W. James.
150	1634	1167	220	16	116	255,679	50,700	Donations, board of Pat'nts, Endowment Fund.	J. C. Burgher.
26	50	50	...	...	....	50,000	None.	Donations.	J. R. Horner.
40	150	140	5	1	3	50,000	None.	Donations.	J. R. Horner.
100	76	60	9	1	6	150,000	None.	Donations.	G. A. Mueller.
150	74	38	13	1	22	100,000	.....	.....	L. G. Rousseau.
100	60	1	57	...	2	90,000	.....	.....	J. H. Thompson.
15	....	...	...	...	....	25,000	None.	Donations.	F. R. Schmucker.
60	70	67	1	...	2	25,000	10,000	.....	C. A. Wilson.
20	3	3	...	...	...	15,000	None.	Donations.	G. A. Mueller.

OF THE STATE OF PENNSYLVANIA.

Incorporated.	Opened to Patients.	No. *new* Patients last year.	No. Patients treated last year.	No. Prescript'ns last year.	Cost of Conducting.	No. visits to Outside Patients.	Delegate.
1848	1848	10,611	12,800	39,476	2,500	2806	C. Mohr.
Not.	1872	.....	...	.....	.....	...	C. Van Artsdalen, C. V. Vischer, Thos. Reading.
1866	1866	9,750	12,000	14,871	.....	76	W. D. King, R. T. White.
1877	1877	2,012	11,674	11,674	.....	941	B. W. James.
1882	1884	1,313	1,756	3,353	.....	305	B. W. James.

HOMŒOPATHIC JOURNALS OF THE STATE OF PENNSYLVANIA.

Names.	Editors and Publishers.	When Established.	Pages in each Number.	Subscription Price.	Delegate.	How often Published.	Form.
Homœopathic Envoy.	E. P. Anschutz, P. O. Box 921, Philadelphia.	1890	8	.25	.....	M'thly	Quarto.
Hahnemannian Monthly.	Dr. W. W. Van Baun, Philadelphia. Drs. Bartlett, Van Lennep, and Van Baun, Phila.	1866	96	$3.00	Clarence Bartlett.	M'thly	Octavo.
Homœopathic Physician.	Dr. Walter M. James, 1125 Spruce St., Phila.	1881	48	2.50	W. M. James.	M'thly	Octavo.
Homœopathic Recorder.	E. P. Anschutz, Philadelphia. Boericke & Tafel, Philadelphia.	1886	48	1.00	.....	Bi-M'y	Octavo.

On motion, the report was accepted and referred to the Committee on President's Address.

Dr. W. J. Martin, Necrologist, then made his report as follows:

NECROLOGIST'S REPORT.

Hermann H. Hofmann died April 4, 1891, at Pittsburgh, Pa. He was born in Rœtha, near Leipsic, Germany, December 21, 1821. His father, who was also a physician, died in 1835, leaving a family of six sons and three daughters in very moderate circumstances. The six sons all became physicians.

Dr. H. H. Hofmann, at an early age, evinced a great desire to become a physician, and with that object in view he pursued his studies with perseverance and under great pecuniary disadvantages. For years it became necessary for him to give private instructions in Greek and Latin to procure sufficient means to continue his studies.

The difficulties that he encountered during his academic and medical studies only tended to increase his determination to accomplish his purpose. It was this perseverance, developed in his early years, that was characteristic of him during his whole professional career.

After completing his studies at the University of Leipsic, he came to the United States in 1849. While in Leipsic he had heard a great deal of and read some about Homœopathy, but never became convinced of the truth of the law of similars until he was induced by Dr. Reichhelm to study it and practically apply it in the great epidemic of cholera soon after his arrival in Pittsburgh. The success with which the scourge was treated by Homœopathists, and especially the fact that during the first week of the epidemic he treated thirty-three cases without a death, while the Old School was losing over fifty per cent. of their cases, convinced him of the superiority of Homœopathy, and he became one of its firmest adherents.

The success attending the treatment of this epidemic established Homœopathy upon a firm basis in this vicinity. This aroused the enmity of the Old-School practitioners, and the open persecution of the followers of Hahnemann commenced. Dr. Hofmann was

their first subject, and suits for malpractice were brought against him. But the determined defence with which these charges were met by the doctor and his friends, Drs. Reichhelm, J. P. Dake, and F. Tandle, showed the animus of the Old School, and the defendant was found "not guilty," much to the discomfiture of his persecutors.

He was strictly a self-made man, fully estimating the full value of honorable conduct, and kindness and charity to all.

He took great pride in extending financial aid to physicians in distress and medical students.

He never tired of giving advice to young physicians, and he esteemed it a favor if he was called out at night in consultation with the younger members of our profession, although he knew that no pecuniary reward awaited him.

His conduct to the profession and his patients endeared him to all. His presence in the sick-room inspired hope and confidence.

His whole professional career and his domestic relations stand as a grand example, to be emulated by us all.

He was an original member of the Homœpathic Medical Society of Allegheny County, and the Homœopathic Medical Society of Pennsylvania, and a Senior Member of the American Institute of Homœopathy.

He was also one of the organizers of the Homœopathic Hospital of Pittsburgh, and took an active part as a member of the Medical Board until near the close of his earthly career.

A widow and two sons survive Dr. Hofmann. One of the latter is Dr. Charles Herman Hofmann of Pittsburgh, a member of this Society, and at the present time President of the Allegheny County Homœopathic Society.

Jacob R. Earhart, M.D., died suddenly on the morning of June 23, 1891, of angina pectoris.

Dr. Earhart was born in Lancaster County, Pa., February 2, 1826. He was seventy-five years old at the time of his death. His father was a Lancaster County farmer, afterwards removing with his family to Franklin County, Ohio. After a few years spent in the public schools of Columbus and vicinity, the subject of this sketch entered the University of Columbus, Ohio. After

graduating he studied medicine in the office of Dr. Luthstram, of Columbus, and assisted the doctor in his practice.

In 1853 he moved to Philadelphia, Pa., and attended two courses of lectures at the Homœopathic Medical College of Pennsylvania, graduating in the spring of 1855. He was a Homœopathic practitioner for thirty-six years. The late Richard R. Gardiner, of Philadelphia, was his preceptor.

Soon after his graduation, Dr. Earhart was appointed house physician to the Homœopathic Hospital, then located on Chestnut Street, near Twenty-fifth Street. Subsequently he was appointed physician-in-chief to the College Dispensary, which position he filled for a number of years. He was also for a number of years on the staff of visiting physicians to the Children's Homœopathic Hospital of Philadelphia; also, one of the consulting physicians to the Hahnemann Hospital, Philadelphia, and also physician to the Home of the Aged, Philadelphia.

He was a member of the American Institute of Homœopathy and of the Pennsylvania State Society, and for several years a member of the Philadelphia County Society.

Since graduating in 1855 he practiced continuously in Philadelphia. He was a staunch Homœopathist and a very successful physician—a student always, and devoted entirely to his profession—a thoroughly conscientious physician.

As to his religion, he was a Swedenborgian, though not a member of the Church. He was a great Bible student. There were few days, indeed, that he missed devoting at least a few minutes to it. In politics he was always a Republican, but took no active part in politics.

Dr. Earhart was never married.

The following obituary notice appeared in the Philadelphia *Evening Bulletin*, shortly after his death: "The death of Jacob R. Earhart, M.D., of this city was a severe loss to the science of Homœopathy in Philadelphia. No man was ever more loyally devoted to his profession than Dr. Earhart. He began practice in his school of medicine at a time when the followers of Hahnemann had not yet outlived the prejudices and distrust which once assailed the doctrines of the great German. It was his satisfaction to see that school develop in Philadelphia from lowly beginnings into a

strong, recognized, and prosperous profession. For nearly forty years he played a useful and honorable part in helping to establish Homœopathy in the confidence of the people of this city, building up a practice which was far more than sufficient to engross all his energies. Quiet, reserved, modest, and unassuming, he was a quick, untiring worker, whose whole time was absorbed in the duties of the profession he loved so well. His gentle and sympathetic nature, coupled with an alert mind and a conscience of the rarest quality, admirably adapted him to the physicians' field of labor. His life would doubtless have been much prolonged if it had not been for the intensity with which he gave himself up to his practice, even in his advancing years. He was not of the kind of men who delight to figure in the public eye; he shrank from publicity and despised familiarity, his character being peculiarly distinguished by a calm and gentle dignity, and his ambition being confined to the promotion of the interests of Homœopathy by his daily demonstrations of its efficacy and value. He was an upright, high-minded man, of whom it may be said without exaggeration that his life was without a blemish. It was one of constant daily beauty, and its memory will be tenderly treasured by those whose privilege it was to enjoy the friendship and ministrations of this wise physician and Christian gentleman."

On motion, the report was accepted and referred for publication.

The Board of Censors, during the session reported the following applicants for membership, and on the recommendation of the Board they were unanimously elected:

REPORT OF THE BOARD OF CENSORS.

J. W. Leckie, M.D., ... Hazleton, Pa.
Hahnemann Medical College, Philadelphia, 1883.

W. H. Lee, M.D., ... New Castle, Pa.
Hahnemann College, Chicago, Ill., 1886.
New York Ophthalmic and Aural, 1891.

R. S. Marshall, M.D., ... Pittsburgh, Pa.
Hahnemann College, Philadelphia, 1890.

G. A. Mueller, M.D., . 35 N. Diamond St., Allegheny, Pa.
Hahnemann College, Chicago, Ill., 1885.

T. L. McDonald, M.D., . . . Washington, D. C.
Hahnemann College, Philadelphia, 1888.

J. C. McCauley, M.D., ... Rochester, Pa.
Cleveland Homœopathic Hospital College, 1890.

Claude R. Norton, M.D., . . . Philadelphia, Pa.
New York Homœopathic Medical College, 1872.

Edward H. Pond, M.D., ... Pittsburgh, Pa.
Homœopathic Medical Dept. of U. of M., 1886.

Joseph R. Phillips, M.D., ... Erie, Pa.
Homœopathic Hospital College, Cleveland, Ohio, 1883.

J. S. Rittenhouse, M.D., ... Reading, Pa.
Hahnemann College, Philadelphia, 1885.

W. R. Stevens, M.D., ... Wilkinsburg, Pa.
Hahnemann College, Chicago, 1887.

H. Brooks Tindall, M.D., . . . Pittsburgh, Pa.
Hahnemann College, Philadelphia, 1890.

R. E. Tomlin, M.D., . . 2113 Franklin St., Phila., Pa.
Hahnemann College, Philadelphia, 1889.

M. A. Wesner, M.D., ... Houtzdale, Pa.
Jefferson Medical College, 1876.

Wm. K. Brown, M.D., ... Philadelphia, Pa.
The University of Pennsylvania, 1872.

C. H. Brown, M.D., ... Philadelphia, Pa.
The University of Pennsylvania, 1878.

F. W. Burlingame, M.D., . . . McKeesport, Pa.
Cleveland Homœopathic Hospital College, 1882.

J. S. Cleeland, M D., ... Freeport, Pa.
Cleveland Homœopathic Hospital College, 1885.

B. L. Davis, M.D., ... Bellevue, Pa.
New York Homœopathic College, 1864.

J. C. Merle Drake, M.D., ... Erie, Pa.
Hahnemann Medical College, Chicago, Ill., 1880.

J. Ely, M.D., ... Washington, Pa.
Pulte Medical College, 1887.

Irwin B. Gilbert, M.D., 2027 Columbia Ave., Phila., Pa.
Hahnemann Medical College, 1882.

Ella D. Goff, M.D., . . 17 Taylor Ave., Allegheny, Pa.
Boston University, 1891.

F. E. Harpel, M.D., ... Danville, Pa.
Hahnemann College, Philadelphia, 1871.

John Kaufman, M.D., ... Hazleton, Pa.
Hahnemann College, Philadelphia, 1888.

D. C. Kline, M.D., . . 209 S. Fifth St., Reading, Pa.
Hahnemann College, Philadelphia, 1883.

J. C. Knauer, M.D., . . 233 S. Ninth St., Reading, Pa.
College of Physicians and Surgeons, Baltimore, Md., 1886.

REPORT OF THE BUREAU OF CLINICAL MEDICINE.

Address of the Chairman, Joseph E. Jones, M.D.
Hip-Joint Disease, by H. M. Bunting, M.D.
Clinical Cases, with Comments, by E. C. Parsons, M.D.
Some Practical Observations About Examinations of the Heart, by E. R. Snader, M.D.
Excessive Medication, by Robert P. Mercer, M.D.
Rheumatic Purpura, by C. Van Artsdalen, M.D.
Lukæmia, by J. Richey Horner, M.D.
Fifty Consecutive Cases of Typhoid Fever, by M. M. Walker, M.D.
Is Diphtheria Contagious? by Joseph E. Jones, M.D.

ADDRESS OF THE CHAIRMAN.

JOSEPH E. JONES, M.D., WEST CHESTER, PA.

THE members of this bureau have been very prompt and diligent in their promises to its demands. Answers from every member have been received, and "all are here or accounted for." The most of the members have answered with a promise, and those who have not, gave good reasons that the claims on their time were excessive, and in justice they should be excused.

Although those who have written were notified of the claims of this society in ample time for the production of a report from each one, yet they would have reported better if they had taken the recommendation of this society, enacted and placed in its by-laws years since, viz., that they prepare and put into the hands of the chairman of the bureau the articles written and fully completed, at least one month before the date of the society's meeting. This has not been done, hence, is not this by-law a dead letter?

The medical diseases that have in a special manner troubled various districts of this State have been la grippe, typhoid fever, dysentery, cholera infantum, cholera morbus, diphtheria, and scarlatina.

The most prominent of these was the epidemic of la grippe which spread its influence over the whole surface of the State so completely that we can hear of no place that escaped its power. The rural districts, although in many places most seriously afflicted, yet, in the aggregate, did not feel its presence so strongly as in the cities and larger towns where the population was more dense, and hence, probably, the germs more concentrated.

Last year we had a statement of its influences and a history of the disease in our bureau report. This year there has been considerable change in its mode of attack, and the violence of its approach has been greatly augmented. The cases were fewer, but those that were taken were attacked more violently, and in many cases great danger was imminent from the first. In no city of Pennsylvania was it so serious in its violence and extent as in the city of Pittsburgh. The number of cases was much increased over that of 1890, and so vehement was its onslaught that for a time business was interfered with, and the death-rate ran high very rapidly. (But just here let it be reported that the death-rate under Homœopathic treatment was remarkably low.)

The fact that the number of cases was so largely increased, and the severity of the symptoms greatly augmented where the centres of population were most dense, would strengthen the conclusion that the disease was wholly bacterial in origin.

The symptoms of this disease commenced in the same catarrhal manner as those of the epidemic of 1890. Chill, coughing, sneezing, violent headache, rheumatic pains all over, distressed the patient, high fever, frequently *very* violent, with great prostration of strength. The weakness, in large degree, seemed to come from a paralyzed condition of the spinal centres, and in many cases the vertebræ were tender to the touch, but nearly every case had over the cervical and lower lumbar regions a sense of great weakness, while with others there was a giving away of the strength, affecting the function and action of the heart, causing irregular pulsations and changes of force. The chest was in many instances

violently congested, and in others paralyzed. So much so was this the case, that huge masses of accumulated mucus would be expectorated, if the patient survived the onslaught and reacted sufficiently to get power to throw off the accumulated morbid products.

Torpidity of the liver was noticed in many instances, with its immediate and consequent symptoms.

Cystitis and nephritis were not rare sequences. In fact, nearly all the grave diseases of the various organs were either brought on, or, if in existence with the commencement of the attack, became seriously aggravated. All portions of the body, connected directly or remotely with the pneumogastric system of nerves, showed the great prostration. A slow convalescence attended not only this disease but all other sickness during the prevalence of the epidemic.

We are pleased to know that the success of its treatment has been universal all over the State by the members of the Homœopathic profession. Seldom was there a case lost when it had been Homœopathically treated from its incipiency, without severe organic disease had held the case before the new attack. This testimony to the credit of the New School system of medicine has been well nigh universal in every part of the State, and should make us better satisfied with our medical power, as this epidemic was a violent one.

The most successful remedies were aconite, belladonna, bryonia, gelsemium, eupatorium perfoliatum, veratrum viride, mercurius solubilis, cimicifuga and lachesis. China and arsenicum assisted much in the convalescence. The above remedies were commonly used where the disease was the most violent.

Other diseases in many parts of the State developed their usual order as to time and district, but not of more than usual number or violence than in former years. Typhoid fever, in places, was prevalent, but the type was mild. Dysentery, cholera morbus and cholera infantum have not been more numerous or violent than in times gone by. Diphtheria and scarlet fever have been noticed in only isolated districts, and not of so fatal character as was formerly observed.

HIP-JOINT DISEASE.

H. M. BUNTING, M.D., NORRISTOWN.

On page 311, in the *Transactions* of this society for the year 1886, I had the privilege of reporting a case of morbus coxarius in a child of three years, treated by me and resulting in his entire recovery.

The case, I then thought and still think, was due to congenital phimosis, for upon examining the penis an opening was found which disclosed but little more than a pinhole meatus, while the foreskin extended fully one-fourth inch in front of the glans.

There was a history of nocturnal enuresis, priapism and nervous troubles. No constitutional dyscrasia could be found. There was absolutely no history of traumatism.

The case, briefly, was treated by absolute rest in bed, with belladonna and calcarea carbonica as remedies. He remained in bed seven weeks, and was then allowed a daily carriage ride and gradual exercise. The length of his walk and time of play was increased every few days.

Splints or extension were not resorted to, nor do I think they were required. The recovery was perfect and his restraint caused very little decrease in weight.

On September 30, 1890, I examined Sarah J., a child of four years, dark hair and complexion, fairly well nourished, but withal delicate-looking, and of a scrofulous dyscrasia, reflected probably from the mother.

About a month before my seeing her, the child fell from a table, and while no apparent injury resulted, she soon complained of pain in the knee and occasionally in the hip. Some home remedies were used and little thought of the case.

Previous to my seeing her, however, her appetite had decreased, she had occasional fever, especially towards evening, crying out in her sleep, and was noticed to tire very easily while walking or playing. Stiffness of limbs was apparent, more marked in the morning; and the parents noticed a shuffling or dragging of the feet.

When brought to my office I had the clothing removed and stood her upon the desk with her back towards me. There was a perceptible flattening of the nates, with a decided drooping and almost obliteration of the gluteo-femoral crease; also a lowering of the pelvis on the affected side.

Placing her now upon the desk on her back and raising the thighs, I brought down the affected leg, which was accompanied by a tilting of the pelvis and arching of the spine. Shocks on the heel, with the leg held at different angles, elicited a complaint of pain in the hip. On standing, the leg appeared lengthened, slightly flexed, and the foot abducted. There was some feeling of tenderness about the joint on handling. Walking showed a dragging gait, and in standing she rested most of the weight upon the sound limb. I diagnosed hip-joint disease in the first stage, and ordered her to be taken home and put to bed. Here came a strong remonstrance from the mother, who said it would not be possible to keep her in bed, as no one could take the time to watch her, but if she were allowed to carry the child down stairs in the day-time she could have her crib there and would be kept in it. On this I compromised, and thought I would gain the end as well, viz., absolute rest for the diseased joint and relief from pressure.

I did not deem extension at all necessary, nor did I resort to it in any manner.

The temperature was still increased in the evenings and her appetite remained poor. Belladonna 3d was given every four hours for a week, and then three times a day. She received no other medicine until December 1st, when, owing to a disposition to head sweat and the temperature having returned to normal, I gave her calcarea carbonica 6th. On the 24th of December she had a few doses of sulphur for constipation, and then, after the correction of this complaint, I returned to calcarea. Her appetite and strength improved very much, and, contrary to my expectation, she gained considerably in flesh.

On the 2d of February, for the first time, I permitted her to stand on the floor, and apart from the clumsy handling of the leg from its long disuse, she walked well, without limp and no stiffness. The nates had ceased to be flattened, the gluteo-femoral

crease was almost even with its fellow, and no tenderness was complained of in the hip.

By the 18th of February the appearance of both nates was alike. I now changed the remedy to sulphur 12th, twice daily, and allowed her to walk for one-half hour at a time in the morning and again in the afternoon.

On March 16th she appeared well, and was told to walk as much as she liked. Since then she has had no medicine, and appears all right.

The parents have just reported the child to be in robust health, strong, and with a good appetite, gaining in flesh and on her feet from morning until night. No tired feeling is complained of, and in every way she seems perfectly well.

DISCUSSION.

Dr. W. G. Dietz: During the past three years I have had three cases similar to those reported by Dr. Bunting. The youngest was a child one year old, the oldest being four years of age. The symptoms were about the same as in Dr. Bunting's case. He thought we are apt to overlook the very first symptoms, ascribing the pain in the knee-joint to a little rheumatism, and fail to investigate further. We always find the gluteo-femoral fold obliterated. In the first case he cited, that of a year-old child, there was a one side movement of the body, and, on extension of the limb, the foot was everted. The child was of a leuco-phlegmatic temperament, and the general health was fair. There had been no history of an injury. He gave calcarea carbonica 6m, and the child was well in three weeks. The next older child was two and one-half years old, and, while walking, fell, with no apparent injury. Some time afterwards, however, the mother noticed symptoms similar to those recorded in Dr. Bunting's case. The treatment was complete rest in bed, and a cure was speedily effected. The third case was an ordinary one, with no specially distinctive features. Here, as in the other two, the cure was effected by complete rest.

Dr. J. C. Sanders said the paper suggested to him an idea concerning the early symptoms. Though the case came in a department of medicine in which he was not especially posted, he had

given considerable time to investigating this subject. He had noticed a symptom which made its appearance considerably earlier than the pain in the knee and the embarrassment of motion, and that is a crying out at night. The child is lying quietly, peacefully sleeping, when suddenly it will scream out as though in extreme pain. Often this symptom precedes an attack of the disease under discussion.

Dr. Joseph E. Jones said that during the last few years he had had a number of cases. He emphasized the absolute necessity of an early diagnosis of the condition. In one case he called to mind, that occurred in a lady aged twenty-five years, the first symptom was an inability to put the foot of the ailing side back of the other one. In walking she had to keep this foot always forward. She was also unable to swing the foot. With this condition there was but little pain. The case proved to be one of extremely severe hip-joint disease. Another case was that of a hearty, stout boy, who was unfortunate enough to possess a donkey. This donkey one day threw the boy over his head, the boy striking his hip against the curbstone. As there seemed to be no injury done, no attention was paid to him. Suppuration developed, and to-day there is a huge running sore. Hepar sulphur is doing this case a great amount of good.

Dr. W. J. Martin said that in his experience it was very difficult to enforce absolute rest. He had had a case where hip-joint disease was rapidly developing. He would not touch it until he was assured that he could have complete control of the boy. Then he sent him to the hospital. Here Sayre's splints were applied. Belladonna and hepar sulphur were the remedies employed, and the case resulted in a complete cure.

Dr. F. R. Schmucker insisted on the necessity of taking measurements in every case, in order to secure a correct diagnosis. When the symptoms of hip-joint disease developed the case should be sent to a hospital immediately, and put in a position of complete rest. In one case he called to mind measurements showed the condition to be undoubtedly present. Rest was procured and treatment continued for several months. The result was a perfect cure, with no sign of lameness. He thought we should always make extension, treating it as a surgical disease, and not relying

on remedies alone. The reason for extension is to take away pressure in the acetabulum.

Dr. H. J. Evans said that in one case he had used Hamilton's double splint with the best of results. In another, surrounding circumstances were such as to prevent the attaining of complete rest, and the result is that the patient is lame to-day. The remedies he had used were calcarea and silica.

Dr. C. P. Seip called attention to the fact that nearly, if not all the cases sent to the hospital, had passed beyond the first stage. Even in these cases good results are obtained from rest, extension, and the indicated remedy. He remembered having seen at a sectional meeting in the American Institute of Homœopathy, a case which had been examined by the best surgeons present. In their opinion anchylosis was bound to result. One of the leading men said positively that no other result could be obtained; but here extension cured. In treating these cases we must have absolute rest and extension. In choosing between a remedy and extension he would prefer to depend on extension.

In answer to a question by Dr. Z. T. Miller as to why extension is necessary, Dr. Schmucker replied that it was necessary to relieve the pressure upon the acetabulum.

Dr. Miller then remarked that since the first symptom was extension, he could not see why more extension was needed. Numerous cases have recovered without any extension at all. Dr. Seip corrected Dr. Miller in his statement that extension was the first symptom. The first sympton is a contraction of the muscles, and this, throwing the head of the bone into the acetabulum, causes the pain, which is relieved by the extension afterward applied.

Further remarks were made by Drs. Dietz and Schmucker, after which Dr. Bunting closed the discussion.

CLINICAL CASES, WITH COMMENTS.

E. C. PARSONS, M.D., MEADVILLE.

Case I.—While practicing as an undergraduate I was called on Thursday evening, October 8, 1874, to visit Mrs. C., aged about twenty-five years, whose education and environment were not only unfavorable to Homœopathy, but were of a character tending to excite the bitterest prejudice, which only her precarious condition, accompanied by a hope not unlike that experienced by a "drowning man grasping at straws," enabled her to overcome.

On arriving at the bedside of this patient, I found her too weak to report her symptoms in detail, but obtained from her husband the following history: She was taken suddenly ill on Monday morning, four days previous to this, my first visit, with great irritability of the stomach, attended by constant nausea and persistent vomiting. There had been great aversion to any food, either liquid or solid, so that the thought of nourishment only served to increase the nausea. Matters had gone on in this way for four days and three nights, under a treatment supposed to be strictly orthodox, with no perceptible improvement. While there had been brief periods of apparent relief from the nausea and vomiting it had seemed only to augment her suffering, as during these intervals the headache, which consisted of a pain in the temples and over the orbits, was greatly aggravated. There had been no menstrual irregularity, no marked error in diet, and prior to the attack she had been in apparent vigor of health. She had just recovered from a paroxysm of vomiting as I entered the room. The pulse was accelerated and weak. There was such pallor of countenance, and she manifested so much exhaustion as to seem like one long and seriously ill.

After obtaining the history and symptoms just narrated, I decided to administer ipecacuanha, the third decimal, ten No. 20 pellets, and just after giving the medicine, placed in her hand a vial containing the first decimal dilution of the same remedy, with instruction to administer by olfaction if there should be any return of the nausea. I sat near her bed, observing carefully the

objective symptoms, and in about one-half hour I noticed the face flush to a bright redness, an increased impulse to the carotids, and upon inquiry learned that the nausea had been relieved, but that she was now suffering from a sense of fulness in the head, attended by a beating or throbbing sensation. I then gave her belladonna, the third decimal, ten No. 20 pellets. The relief obtained was so effectual and prompt as to be a happy surprise to both patient and friends. In one hour after entering the room I had the pleasure of seeing my patient enjoying a quiet and refreshing sleep, which continued, with occasional wakeful intervals necessitating but little further medication, during the night. The next morning the patient partook of a light fluid breakfast, and the case progressed to an early convalescence.

That the result witnessed in this case, following so closely the use of the indicated remedies, was only a coincidence, is not reasonable nor probable, as the case was typical in point of the gastric symptoms of cases in which ipecacuanha is usually followed by prompt relief. The headache also was of a character such as is very commonly relieved by the remedy here given.

Case II.—I was called, March 26, 1880, to see M. P., a girl aged ten years, who was suffering from diphtheria of a very malignant type. She had been ill about five days, during which time she had been under the professional care of one of the leading Old-School physicians of the place, who had committed himself as to the diagnosis and prognosis in such a public manner as to make an honorable retreat impossible, having notified the school board and the board of public health that the case was one of malignant diphtheria and would necessarily prove fatal, as such was the serious result obtained in all cases of like character.

An examination of the throat revealed the fact that the tonsils, soft palate, and posterior wall of the pharynx were completely covered with pseudo-membrane of a dark-gray color. The tongue was foul, and the broken-down exudation from the nose and mouth rendered the breath so intolerably offensive as to beggar description. Indeed, one or more of the attendants were so affected by the foul exhalations as to induce extreme nausea and vomiting. The glands of the neck were swollen, the face bloated, and the expression of the countenance such as to indicate great distress and

physical suffering. The fœtid discharge, the dirty gray color of the membrane, the œdematous condition of the uvula, the great difficulty in swallowing, which excited extreme pain, extending to the ears, the thirstlessness, the debility, and the aggravation from heat, were symptoms which prompted the selection of apis mellifica as the indicated remedy, which was given in the third decimal dilution, and a gargle of dilute alcohol used frequently and persistently.

Improvement was apparent within twenty-four hours, and progressed slowly without the aid of other remedies, save lachesis, which was used later upon the following indications: Liquids swallowed with more difficulty than solids, and escaping through the nose with each attempt at deglutition; paroxysms of suffocation, which were worse after sleeping.

The result obtained in this case, gratifying as it was, certainly cannot be chargeable to a mistaken diagnosis, for that had been strictly "*regular*," nor to the exercise of that high degree of faith sometimes attributed to our patrons (but never, or hardly ever, to those of our professional opponents), as this patient was too young to exercise this quality, and the parents had avowed their lack of confidence, and only consented to the method of treatment adopted at the earnest solicitation of a friend, after they had been led to believe that the case was hopeless.

Case III.—Mr. W. D., forty-six years of age, by occupation a farmer, was attacked with la grippe on the first day of February of the present year. For some months prior to this date he had suffered from considerable general weakness, slight indigestion, and at times severe pain in the lumbar region of the spine. He was quite sick from the beginning of the attack of la grippe, the disease assuming the form of an acute tonsilitis, attended by the usual catarrhal condition, muscular soreness, prostration, and other usual accompanying symptoms. After about three weeks he began to convalesce slowly, and the improvement continued until March 7th, when a relapse occurred, assuming at this time the form of an acute catarrh of the stomach and bowels, accompanied by great thirst and a sense of fulness and bloated feeling in stomach and bowels. This condition continued without material abatement until April 1st.

For the first two months this patient was under the care of a magnetic healer, so called; but failing to obtain relief, a "*regular of the regulars*" was called to take charge of the case for the next three weeks, but all to no purpose, except, possibly, to aggravate the already seriously impaired digestive function and render his weakened condition still weaker by administering massive doses of cathartics and other drugs.

I was called to visit this case April 17th, two and a half months subsequent to the attack of la grippe. He was despondent, his face sunken and pale, and he could not permit his head to be raised from the pillow without developing symptoms of threatening syncope. There was muscular weakness of the heart, attended with a sensation of coldness over the whole body, which was bathed at times with a profuse perspiration. The tongue was heavily coated white, and there was complete loss of appetite, with almost constant eructations of gas during waking hours. At this time the bowels were constipated, the fæces dry, indurated and covered with mucus.

Several remedies were used during the first two weeks, as thought to be indicated, such as nux vomica, bryonia, and lycopodium, none of which seemed to produce any very salutary effect, although there was slight improvement in strength, due perhaps wholly to the nutritive enemas, which were used twice daily. The stomach was allowed to rest, except that he took a little liquid peptonoid occasionally, and only as his usual disinclination yielded to the importunity of his devoted wife, who was his constant attendant.

About the 1st of May, while trying to elicit further symptoms, in the hope that some more efficacious remedy might be selected, he stated that he had a craving appetite for sugar. This key-note, with a more careful study of the symptoms in detail, lead to the selection of argentum nitricum, which was given in the sixth decimal potency, two grains dissolved in one-fourth of a glass of water, two teaspoonfuls of this solution administered every two hours. Improvement was apparent within twenty-four hours after beginning the use of the remedy, and continued, without serious interruption, for two weeks, when the advance toward recovery was less rapid, and the thirtieth potency of the same remedy was given at longer intervals with excellent effect throughout the

remaining period of convalescence, so that treatment was practically discontinued July 1st.

At this writing, September 2d, he reports himself well and able to follow his vocation.

It is with a thorough appreciation of the fact that the cases here reported are wanting in that precision and accurate detail of course and symptoms, together with dose and repetition of each remedy, which should characterize a clinical report of this kind.

It has not been my hope, nor expectation, to make this paper a model in any respect. Besides, my case-book is wanting in many points of accurate clinical record. It is no spirit of arrogance, nor of boastful conceit, that prompted this report, as I know full well that many of my colleagues of like faith and practice are exemplifying this law of therapeutics in practice with more brilliant results than any witnessed by myself.

In the preparation of this paper it has been my object to give a clinical confirmation of each remedy used and to inspire confidence in the minds of the wavering and such as doubt the efficacy of the agents we have at hand for the arrest of disease, by showing the prompt results attained when put to the test of experience, and that, too, in cases which have persistently withstood Old-School medication. In order that one may arrive at a correct conclusion as to which is the more scientific and effective system of practice, it is necessary that he should compare statistics and become familiar with the practical workings of each system. It therefore becomes the duty of every Homœopathic practitioner to aid in the dissemination of such facts, from clinical experience, as will tend to advance scientific medicine among those who may be in search of the truth upon which to predicate their faith, to remove the doubt of the incredulous, and to silence the scoffing opposition of the known and avowed enemies of our cause.

The desperate efforts which have recently been made by the dominant school to maintain her strong hold upon public and private patronage by endeavoring to control legislative action in this and other States, is rather conclusive evidence that she fears the result of untrammelled competition and anticipates a possible succession in power.

It is somewhat refreshing, since the smoke of the recent battle

for principle and equal rights before the law, in this State, has scarcely cleared away, to look back along the line of march and review some of the successes which have attended the new system of therapeutics since that period in the early history of our school, at Leipsic, when Hahnemann treated seventy-three cases of malignant typhus, with only one death, to the very recent experience gathered from the Registry of Vital Statistics in the neighboring city of Buffalo, where the ratio of deaths, for a given week, was as ten to sixty-three in our favor.

Witness, too, the results obtained in field and hospital practice by the late Dr. Franklin, who brought to his aid Homœopathic therapeutics, and who, at the United States General Hospital at Mound City, Mo., was able to show a less percentage of deaths than any other hospital during the rebellion.

Witness the statistics collected and reported to this Society in the able address of its president three years ago, relating especially to the treatment of insanity and pneumonia, a summary of which shows a ratio of death-rate of four to seven in the former disease, and six to twenty in the latter, in favor of the Homœopathic treatment.

Witness, also, the comparisons which have frequently been made as to the relative value of the two methods in the treatment of cholera, yellow fever, diphtheria, scarlet fever, and other severe forms of disease, where reliable statistics have been available, and, so far as known, the test has always been favorable to our method.

Notwithstanding the past success attained under this law of remedial selection, we are urged to abandon our distinctive title, "cease to practice an exclusive dogma, and stand upon the broad foundation—(regular) *physician* in all that the name implies."

In order to do this we must sacrifice truth to error, adopt methods which both experience and conscience condemn, and sell our birthright under Hahnemann for the pottage of Old-School experimentation, such as Declat's phenic acid, Bergeon's rectal injections, Brown-Sequard's elixir, Koch's lymph, and all the speculative nonsense in the line of disease specifics that may yet be advocated by any Æsculapian visionary, provided only and always that the author is a "*regular*."

It is to be admitted and regretted that some, claiming to march under the banner of Homœopathy, rather than give that careful study necessary to the selection of the true similimum, resort to unscientific generalizing, or adopt any new experiment which may have no foundation in principle, only to find themselves humiliated and chagrined by the results of such fruitless prescribing.

Hahnemann built upon a vital and imperishable principle. He founded the New School upon eternal verities. He laid the foundation upon the bed-rock of immovable truth. In order to advance our cause, we must search for the same foundation upon which to build.

Our cause is doctrinal as well as ethical; and because we believe that the principles of the former embraces the law of similars as the true guide for the selection of remedial agents, we are charged with the sin of practicing an exclusive dogma, and, therefore, ostracized by the dominant school as medical heretics, and denied that professional relationship which any proper conception of human duty would regard as necessary to the embodiment of the first principles of ethics.

What matters it if they do laugh at our principles and deride our creed, so long as we are able to cite innumerable competitive test cases and abundant statistics from hospital and private practice in confirmation of our faith, and as the best possible proof that ours is the better way. Surely the most conclusive and triumphant method of proving any principle involving human duty is to use it. Put it to the test of experience. Having thus proved it as a fact, it merits our admiration as any other established truth, and we lose sight of the dogma.

We believe that history and experience proves that in the practice of Homœopathy we are able to attain nearer "the physician's highest and only calling" by restoring to health a larger percentage of cases treated, and that, too, by a method more "speedy, gentle, and permanent."

Heretofore, the Homœopathic School has acted upon the line of the defensive, which, for many reasons, perhaps, has been the better course; but we believe that the time has fully come when she should assume a more aggressive position, and demand for her votaries equal rights before the law.

The partnership of the government, municipal, state, or general, with sects in medicine is as offensive and unjust as with sects in religion, and the interest and safety of our cause depends upon a united effort to break up such an alliance wherever it exists.

Until we secure that recognition which equity demands, are we not justified in the exercise of a little more boldness in acquainting the general public with the success attending our methods by collecting and publishing available statistics bearing upon this subject?

It becomes our duty to encourage a more general patronage of Homœopathic publications, both text-books and journals, and in this way aid in promoting the highest possible standard of both. We should also support the colleges of our school, already established, by our influence and means, and discourage the establishment of new ones, which, from the lack of strength of support, must necessarily fail to wield a salutary influence.

Every possible effort should be made to encourage Homœopathic practitioners to join our societies, and thus become identified with a united force against every repressive legislative measure.

If all interested would clasp hands in that enthusiastic support which the merits of our cause demands, it would shake the citadel of old Physic, and hasten the time when adherence to traditional medicine will cease to be the essential qualification necessary to command public favor and secure appointments to positions in our State and municipal hospitals, and upon the medical boards of the army and navy.

The reading of this paper brought forth from Dr. Jones the remark that while he was a graduate from the old school of medicine, he wanted to enter his protest against the habit of calling physicians of that school "regulars."

Dr. Korndœrfer remarked that the school of Homœopathy is the oldest, as, outside of a few standard prescriptions, the oldest treatment in the dominant system of medicine was first advocated less than ten years ago.

SOME PRACTICAL OBSERVATIONS CONCERNING EXAMINATIONS OF THE HEART.

E. R. SNADER, M.D., PHILADELPHIA.

It is certainly true that a mere theoretical knowledge of the morbid conditions that may affect the cardiac apparatus is insufficient for diagnostic purposes. Even a knowledge of the physiological cycle of labor performed by the heart, while of necessity an absolute essential to the correct understanding of the morbid alterations that occur in the central circulatory organ, is not sufficient to insure a correct diagnosis of an abnormal condition. An understanding of the normal workings and evolutions of the heart, as well as a theoretical knowledge of the morbid conditions incident to disease of that organ, must be supplemented by a practical knowledge—a working knowledge, a comprehensive knowledge, a discriminating knowledge—in other words, the phenomena discovered must be weighed by a correctly-balanced judgment and an exquisitely-poised power of discrimination.

The text-books attempt to lay down, rather dogmatically it seems to me, iron-clad laws for diagnosis. Even he who reads between the lines, and attempts to gain a comprehensive grasp of the steps necessary to arrive at a correct solution of a problem in cardiac diagnosis, is struck, on the one hand, with the positiveness of assertion regarding the diagnostic criteria available for the diagnosis of certain lesions, and, on the other, by the vagueness and uncertainty of groups of symptoms and physical signs present during life, and the definiteness of the lesions discernible after death.

It seems to me, that in order to interrogate the heart properly for morbid conditions, that organ must be investigated from at least two standpoints: First, as a pump, acting on strictly mechanical principles; and, second, as a vital organ.

As a pump, the heart is subject to the laws of mechanics, and alterations in the physical conditions under which it works act directly or indirectly upon the cardiac structure. It is a central

organ, and the larger and peripheral avenues for the course of the propelled current of blood must be regarded as essential parts of the blood-propelling apparatus. In other words, the heart itself must not alone be considered; the arteries and the veins must be taken into account as essential parts of the circulating mechanism, and, in some instances, the organs and tissues through which the arterial and venous tides flow, must be investigated for causes interfering with the work and action of the heart.

As a vital organ, the heart may be acting abnormally independently of any known disease. As a vital organ, too, the heart dominates the pumps; and, however perfect, as a piece of mechanism the heart's propelling power, it may be affected by the action of the heart as a vital organ. As a vital organ the heart can be disturbed by many trivial as well as by grave tissue alterations, the result of local or general disease; it may be disturbed by systemic states, not actually normal, to which we have not, as yet, been able to give definite and distinctive names; it may be disturbed by the influence of the will, by psychical states, by emotions, by exertion, by temperature alterations, and by many other factors.

The heart, then, is a pump, dominated by its intrinsic nature as a vital organ, and, as a vital organ, is subject to various influences having their their origin outside itself, as well as to disorders peculiar to its own structure. The heart is a heart, but it is also part of a systemic whole. The specialism that fails to recognize the organ in its relations to the whole man, as a psychio-physical, as well as mechanical creation, is unworthy the name.

Viewing the heart, then, from the standpoints of a pump and of a vital organ, we examine the organ:

First, as to the condition of its walls.

Second, as to the condition of its cavities.

Third, as to the condition of its orifices and valves.

Fourth, as to its condition as a vital organ.

Fifth, as to its relations to the system at large.

Now, while this method of examination is apparently systematically elaborate, as a rule, an ordinarily skilful examiner really takes cognizance of the varied factors furnished for diagnostic purposes, at one time, *i.e.*, by a process of rapid cerebration all the

points are readily, almost unconsciously, summarized, and frequently a positive diagnostic conclusion can be arrived at from a single rapid examination of the heart. The method is simply given to give direction to thought—to concentrate the objects of the examination. (The last-mentioned procedure—the interrogation of the system at large in its relation to the heart, and of the heart in its relation to the organism—frequently requires extensive physical exploration.

It is not the intention of this paper to systematically treat of the rules and methods of procedure in cardiac diagnosis. I do not wish to make a recapitulation of standard knowledge; that would transcend the scope of my paper, which I do not intend shall be exhaustive of the subject. I simply want to point out some manifest mis-statements of the text-books, and, in a desultory way, present some observations that may be of service to you in examining hearts, and to insist that practical experience alone can determine the value of diagnostic criteria, and to protest against the application of arbitrary and acoustic laws to the solution of questions in cardiac diagnosis.

Let me speak a few words about valvular lesions. The text-books point out certain regions in which you must hear heart-murmurs originating at certain orifices or valves. For instance, the diagnostic features of mitral regurgitation are given briefly as follows: A murmur heard with the systole, having its maximum of intensity at or near the apex, and transmitted laterally around the left side of the chest, and often heard on the posterior aspect of the chest near the lower angle of the left scapula.

In point of fact, mitral regurgitation exists without any such localization of intensity or line of transmission. I have heard a murmur of mitral origin three inches below the left nipple possessing at this point its maximum of intensity, the first sound in the mitral area being simply blurred. I have found murmurs also of mitral origin an inch from the sternum, and also midway between the apex and base of the heart, and also two inches outside the left nipple, low down. I have frequently found murmurs originating at the mitral orifice, best transmitted to the apex of the left lung, about two inches below the clavicle, when there was a feeble or no lateral transmission whatever. In fact, I have been led to

investigate the heart for valvular disease by discovering a murmur so transmitted while examining the respiratory organs. The transmission has occurred when the left lung was solidified and when it was not. I have heard mitral murmurs that were transmitted all over both chests, over the upper portion of the abdomen and were even detectable in the neck.

The diagnostic evidence of the mitral origin of these anomalous (?) murmurs was an impairment of the mitral valvular element of the first sound, the normality of the valvular part of the tricuspid first sound, the accentuation of the pulmonary second sound, together with a predominating hypertrophy of the right ventricle.

If it were accepted as an arbitrarily fixed fact that a murmur originating at the mitral orifice must have its maximum of intensity at or near the apex beat and a certain definite line of transmission, such murmurs as I have described would have remained undiscovered or wrongly attributed to lesions occurring at other cardiac openings.

The difficulties experienced by some practitioners in discovering valvular lesions arise from several causes. Aside from a too close adherence to text-book facts, the principal reasons for failure are, I believe, a misapprehension of the nature of the signs indicating valvular lesions, a preconception of the character of the sound or sounds they are searching for, and the mental retention of an ideal murmur to which all sounds are compared, together with an inability to concentrate the mental faculties exclusively on the sounds to be studied, a lack of practice, and an uneducated ear.

A murmur is a *new sound*, preceding, following, adding to or replacing the normal cardiac sounds. Murmurs vary greatly in their sound characters. If the last sentence be fully appreciated, and a murmur is understood to be a new, an added, an abnormal sound element, a proper conception will be had of the nature of murmurs. No two murmurs are precisely alike in all respects, and you can readily see that if a practitioner compares a sound he is studying with the characters of a sound he has heard in another patient, he will of necessity be dominated by a false standard. The ear can readily be educated to appreciate the slightest modifications in the cardiac sounds and intervals.

It is a mistake, at least for those who have but little practice in

cardiac diagnosis, to fail to review cases after the diagnosis has once been made. It was formerly my habit, after having made an elaborate diagnosis, to study the heart sounds at every visit, as if I did not know what was wrong. By close attention to minute changes, I learned every twist and turn of the heart, and soon became able to note the slightest modifications in the intensity, pitch, or quality of the murmur, and also the changes taking place in apparently unaffected cardiac sounds. Others, I am sure, can acquire equal skill. I learned in this way that the dictum of the text-books that organic murmurs do not change in intensity was untrue.

Murmurs vary in intensity according to the activity of the heart and according to the force of the systole. It is quite possible that a peculiar arrangement of the obstruction of the orifice or irregularity of the valves, for acoustic and mechanical reasons, may have much to do with the intensity of a murmur, but I am confident that the force with which the blood is propelled against the obstacle is a factor of infinitely greater prominence than the mere position of the lesion. Indeed, I look with much suspicion, prognostically, on a murmur that during repeated examinations *gradually* diminishes in intensity under my observation (other factors being equal). The inference I draw from such a decrease is that rupture of the compensating hypertrophy is occurring, and ventricular dilatation is imminent or at hand. As I mentioned before, I have known of murmurs that could be heard readily at any part on the chest. Not only the so-called characteristic transmissions were present, but as I have just said, the abnormal sounds could be heard anywhere over the thorax. I have known, too, these same murmurs to become so diminished in intensity as to be scarcely audible, and while, had I seen such cases for the first time, I would have been able to diagnose dilatation of the ventricles, it is questionable whether I should have been certain of determining that the dilations were sequential to valvular disease. I have noted, too, murmurs that diminished in intensity without there being present any signs of cardiac failure whatever. I have known a murmur to alter in its intensity to such an extent that, while at one examination there was no difficulty whatever in detecting it, at another examination the murmur was

scarcely at all audible, and sometimes all the concomitant evidence of valvular imperfection shown at other orifices had to be summed up elaborately before I could convince myself that my first diagnosis had not been an erroneous one. However, I soon grew accustomed to these variations in intensity. At first I suspected that my hearing was at fault, rather than that the text-books were possibly in error. As a check to myself in these cases where I discovered diminished intensity, on the same day I re-examined other cases that were familiar to me, and found no difficulty in detecting the murmurs. This experience occurred so often that I finally believed that the murmurs altered in intensity, rather than that my aural power of detection underwent fluctuations that would render it impossible for me to rely upon my power of hearing. My conclusion seemed to me perfectly rational.

You can now see why some murmurs are not transmitted characteristically, and also why concomitant evidence is quite as valuable in diagnosing valvular lesions as the presence of murmurs. Poorly transmitted murmurs, weak in intensity, are more difficult to recognize than the so-called characteristic ones, but the recognition of the slight ones is of far more importance, both in a prognostic and therapeutic sense, than the murmurs so readily appreciable, and of which the text-books tell you.

Palpitation of the heart will increase the intensity of a previously-present murmur greatly, but still slighter causes, sometimes appreciable and sometimes not, will cause the same change. I have learned, too, that a murmur occurring during palpitation of the heart is not of necessity organic in origin, but that it is organic in nine cases out of ten under these circumstances, the violence of cardiac action simply bringing the valve deficiency into prominence. If the heart sounds be blurred during intervals of freedom from palpitation, either systolic or diastolic asynchronism exists, or there is a valvular lesion.

I have learned that aortic stenotic murmurs can be transmitted downward with greater intensity than upward, and are even, in some cases, not transmitted at all into the carotids. The diagnostic evidence in such cases was complete as to the character of the lesion. I recall the data in one instance: A murmur heard con-

stantly over the aortic area, with the first sound, the systolic sound being notably impaired, the second decidedly accentuated, with a decided hypertrophy of the left ventricle, with inconstant systolic murmurs heard over the tricuspid and mitral areas. Anæmia was not present in these cases.

There are several possible sources of error in searching for cardiac murmurs upon which I desire to lay special stress. When the ear is imperfectly approximated to the chest over the apex or other regions, the impulse frequently makes a consonating chamber of the auditory canal and external ear, and simulates a systolic murmur very closely. It is differentiated from a real murmur by its closeness to the ear and its disappearance when the ear is firmly pressed to the naked chest, this action excluding all sounds save those coming from within the thorax, and also by the use of the stethoscope.

The boom of an hypertrophical heart, by reason of its so-called tinnitus, is also liable to be mistaken for a genuine murmur. This sound is differentiated from a sign indicating a valvular lesion by the fact that the valvular element of the systolic sound (the only sound producing the sort of tinnitus likely to lead to error) is normal, or simply presents the modifications incident to the hypertrophy.

The rubbing of the clothing upon the chest can simulate a murmur. A lack of synchronism with the cardiac sounds or their intervals differentiates this apparently abnormal sound, and the removal of the clothing settles the point beyond peradventure. In making delicate comparisons of the cardiac sounds the præcordial region should always be bared.

Wax in the examining ear is a common source of error. Nearness to the ear differentiates sounds so produced from those indicative of serious lesions. I have made repeated examinations with quite a collection of wax in my ear, and have simply made allowance for the sound elements produced by the wax, and have been led into no errors in diagnosis, for I have by subsequent examinations, when my ear was free from wax, confirmed my first findings.

Another source of error, personal to me, I presume, is a distinct murmur that occurs in my own ear, at times, after much stoop-

ing, exertion, or drinking water. With every systole I could hear in my own ear, whether examining or not, and especially if there was absolute quiet, a distinct murmur. I learned to make successful examinations even during the temporary presence of this murmur. I shall not waste time in an attempt to explain the mechanism of this sound. Suffice it to say I differentiate it from a murmur I hear in a patient, if I do hear one, by its being directly in the ear, and by the fact that it is synchronous with my radial pulse, and asynchronous with the pulse of the subject of examination. If the patient's pulse agrees with mine, I have him exercise until I run the patient's pulse up ten or twenty beats more than my own. I have, in these cases, too, made subsequent examinations and compared the results of my first observations.

The respiratory sounds are not infrequently sources of error. They can be usually made to disappear by suspending the respiratory acts. A still graver source of error, also connected with the sounds originating in the lungs, occurs when the lung deeply overlaps the mitral area, and the impulse of the heart with each stroke drives the air forcibly through the vesicles impinged against the chest-wall, producing with each impulse an apparent systolic murmur. Great care is sometimes requisite to avoid mistaking this systolic sound for a murmur indicating either mitral regurgitation or a mitral intra-ventricular lesion. I employ several measures to determine whether the murmur originating as I have described really has its source in the mitral area or not, and by careful attention to concomitant evidence it is always possible to determine the murmur's exact origin, and even to make out with positiveness the coexistence of an organic murmur with a lung murmur, as I term the sound under consideration. If the mitral valvular element of the first sound retains its normal purity, I am sure that the murmur heard originates as I have described, and that the mitral valve is normal. This lung murmur, inasmuch as the quantity of air in the impinged vesicles varies relatively during several beats of the heart, even although the sound is apparently synchronous with the systole, fluctuates in intensity, is irregular as to length, and sometimes betrays the breezy quality of the respiratory murmur. By suspending respiration, and examining during both forced inspiration and forced expiration, I

am ultimately enabled to study the cardiac sounds, and determine upon their normality or abnormality. I sometimes put the patient on the left side and then secure a forced and held respiration, until the vocal resonance has disappeared from the mitral area, and I then study the signs originating at the mitral orifice from beneath. I sometimes study the sounds originating at the tricuspid orifice (both the impulse and valvular element of the first sound), and then, by comparison, my ear still being in the tricuspid area, study the mitral sounds, and make comparisons undisturbed by the lung murmur. This comparison requires the greatest possible mental concentration.

Murmurs, too, are often heard without lesion, when there exists a cavity in the left lung. They are apparently due to the systolic agitation of the air in the cavity. I need not refer to the murmurs so commonly found in phthisical patients, over the pulmonary area, or in sub-clavian artery, or to the anæmic murmurs.

There is one statement in the text-books that is full of significance, and to which half enough attention has not been given by the vast majority of examiners. I refer to the statement that murmurs are sometimes heard in the recumbent position when they are not audible in the standing position. Too much insistance cannot be laid upon the necessity of examining for murmurs in both the standing and recumbent postures. In the text-books the fact is stated baldly, when it should be emphasized strongly. I hold it as of cardinal importance in cardiac diagnosis that the subject should be examined lying as well as standing when lesions are not discovered when the subject is examined in the upright position. An examination is never complete without this procedure. An opinion given as to the condition of the heart from an examination when the patient is standing, is comparatively valueless as to the non-existence of valvular lesions, particularly. An opinion given from an examination without this precaution, amounts simply to the negative declaration that there is no evidence of the existence of a valvular lesion while the patient is examined standing. Such an opinion is partial, incomplete, unscientific, misleading, and is positively a reflection on the diagnostic skill of the examiner. I have diagnosed lesions affecting the valves and orifices of the heart quite a number of times, when

good men, who are undoubtedly able to detect changes in the cardiac sounds, have declared the heart examined normal, or, at least, have positively and decidedly declared that no valvular lesions existed. I have myself, by failure to attend to this precaution, at least twice made the blunder of declaring the heart simply deranged functionally, when subsequent examinations, under different circumstances, betrayed well-marked murmurs, indicative of gross organic and orificial lesions. I am positive, from associated facts, and a combination of presumptive evidence, that the lesions had not arisen since my previous examinations. The simple truth is, that the lesions, well marked and unmistakable, had escaped my ear because of my failure to observe the precaution of examining the heart while the patient was in different positions before I gave my opinion as to the nature of the heart trouble. Various causes, some not well understood, contribute to make a murmur more audible, or only audible, in certain positions of the body. In one case the boom of the systole of an hypertrophied heart—hypertrophied secondarily to a valvular lesion—was so great as to completely obscure the sound of the murmur. The lying position carried the apex away from the chest-wall, and with it the boom of the first sound, and permitted of the ready appreciation of a well-marked and unmistakable systolic murmur. It is not within the intention of this paper to attempt the further elucidation of possible causes of the failure to hear murmurs in certain positions.

I find a stethoscope a useful instrument in these differentiations, yet I must say that there is a possible source of error attached to its use. It appears to be a general belief that if a murmur is not discovered by a stethoscope, no murmur exists. The instrument is made, apparently, an instrument of precision and decision. This is a mistake. I have found murmurs with the naked ear that I did not find with the stethoscope. The naked ear takes in sounds from a larger area, and is, therefore, of greater value in finding abnormalities. The stethoscope intensifies sound, and should be used as a check, and is useful in locating the exact point of origin of the abnormal sound, but is not so good for the mere detection of the fact of the existence of a murmur. Neither the ear nor the stethoscope should be used exclusively. Perhaps

one reason why the ear discovers murmurs not heard with the stethoscope finds its explanation in the fact that when the instrument is used, the regions arbitrarily marked out in the text-books as the points at which certain murmurs are to be looked for, only are explored. As a clinical fact, murmurs are frequently discovered outside the boundaries so elaborately laid out by systematic writers on physical diagnosis.

Keeping in mind the precautions I have endeavored to point out, and keeping also in constant view the possible sources of error in searching for a valvular lesion, it is to be borne in mind that a murmur is an added modification of the normal heart-sounds, or a sound or sounds occurring during the intervals between the beats—a modification that has varying degrees of intensity, pitch, quality, and rhythm, in different cases. In general, it may be said that no two murmurs are exactly alike, as I before intimated. A modification of the heart-sounds, a blurring, an impairment of their purity, should immediately suggest the possibility of a valvular or orificial lesion; and the murmur indicating the lesion should be sought for, not only in the positions pointed out in the text-books, but everywhere within the præcordial region, and even three or four inches outside that area. By such a systematic search you will often be rewarded by the discovery of a murmur, and then, by a careful study of all the elements of the heart-sounds, will also be able, in the majority of instances, to locate the lesion at its proper orifice or valve, and determine, also, whether the murmur is organic or inorganic, and whether, if organic, it is compensated fully or not, and, whether the murmur discovered indicates regurgitation, obstruction, or, even if organic, it be inoccuous.

A murmur having the same pitch as the respiratory sounds is at times difficult of detection, yet by careful attention to all points it is usually detectable. I generally increase the force of the respiration, and by this procedure I increase the intensity of the respiratory murmur, and the difference in the intensity of the heart murmur and the lung sounds assists in the recognition of the valvular abnormality. The alterations in the valvular sound elements and the fact of enlargement of the heart also assists in many cases.

In listening for murmurs, frequently, a slight blurring of the heart-sounds will be the only obvious change suggesting abnormality; but after a long search a murmur will sometimes strike your ear, and afterwards you can hear it without difficulty. Such a murmur, perhaps at first only audible while the patient suspends respiration, can then be distinctly recognized as specially cardiac, by reason of its peculiar sound-characters, no matter how intense the respiratory sounds may be. Slight murmurs it is almost impossible to recognize at first. The ear should remain a considerable time over the investigated area, until *all* the sound elements are distinctly recognizable and differentiable. A murmur heard when the sounds of respiration are suspended should always be listened for, after recognition, whi'e the respiratory murmur is active.

If doubt exist as to whether a murmur has been heard, take the totality of all the physical signs into consideration, before deciding that a murmur is not present. In point of fact, concomitant evidence, pointing to the existence of a valvular lesion, is quite as valuable, in many instances at least, as to the existence of a valvular lesion, as a murmur itself. I have diagnosed the presence of lesions involving regurgitation at the mitral orifice without any murmur at all, and have subsequently confirmed the diagnosis. Under the administration of heart-tonics the cardiac muscle was better able to do its work, and the murmur indicative of the lesion has, later, become plainly evident. In one instance the murmur again disappeared when the heart became more markedly dilated. The dictum of the text-books that absence of murmur indicates absence of valvular or orificial lesions, is only relatively, not absolutely true.

Nor is a murmur indicative of a valvular lesion, constant in another sense, *i.e.*, always heard with every heart-sound. This is notably true where there exists reduplication of the heart-sounds. The murmur may be absent for several beats, and, when heard, is not always as exactly synchronous with the sound that concomitant evidence shows should be the sound with which the murmur should occur. If we accepted theoretical and acoustic reasons as infallible, instead of clinical experience, these cases would be regarded as anomalous, and the difficulties of diagnosis would be increased rather than diminished.

A blurred heart sound, however, does not always indicate a lesion affecting the cardiac valves or openings. It sometimes indicates a slight degree of asynchronism in the systole of the ventricles, an asynchronism not sufficiently marked to give rise to a pronounced reduplication of the heart sounds. In such cases the absence of a positive murmur, the presence of the blur with the first sounds as heard *at all* the orifices, the general feebleness of the circulation, and the discovery of some source of obstruction in front of the ventricles, with other evidences different in different cases, will assist in determining the condition causing the blurring. Generally the blurring is caused by a failure of the compensation in valvular disease, the beginning break-down of an hypertrophy unequal to the task of compensation, and is a condition requiring active therapeutic interference, or it indicates the oncoming of heart failure in acute diseases.

During acute diseases of an adynamic type, a blurring, and sometimes, indeed, a positive murmur is heard, presumably not due to the supervention of an endocarditis, inasmuch as subsequent examinations after recovery disclose no cardiac lesions. There are two possible explanations of the origin of this blurring, aside from the occurrence of the dangerous asynchronism I have just pointed out. The changed character of the blood elements may account for the modification of the systolic sounds, but a more probable explanation is that the papillary muscles lack tension, in consequence of the lack of nutritive elements in the impoverished and changed blood, and the lack of tension in the muscles renders possible such alterations in the valves as to cause the blurring or murmurs. This sort of blurring must be carefully discriminated from the one indicative of asynchronism, and this discrimination is largely made by a study of the modifications of the intervals of the heart sounds. Practically, however, it is well to know that all murmurs heard during acute illnesses are not of necessity due to the supervention of an endocarditis.

I want to say just here that if a valvular or orificial lesion be discovered during the course of an examination, it is not always the lesion that is responsible for the symptoms of which the patient complains. It would be a serious mistake to believe that simply because a lesion was discovered, that of necessity the car-

diac symptoms and cardiac irregularity were due to that lesion. In practice this error is often committed by otherwise competent men. In point of fact, I have succeeded in greatly ameliorating the condition of patients who have been treated for the results of a ruptured compensation, when in reality the compensation was perfect. A discovery of a valvular or orificial lesion has often been considered to be the cause of disturbances in cardiac rhythm and of special symptoms. To be quite plain, functional heart disorders and valvular lesions often coexist. It is simply folly to direct your therapeutic measures toward the restoration of a compensation that needs no restoration, or, in other language, to make the mistake in judgment of considering valvular lesions with perfect compensation responsible for disturbances of rhythm and other cardiac phenomena. Therapeutic measures so directed are calculated to do more damage than good. When the heart has not failed as a cardiac pump, when the heart sounds are normal in their intensity (exclusive of the changes made by the valvular lesion), when there is neither asynchronism nor reduplication, when the long and short pauses of the cardiac revolutions preserve their normal relationship to the heart sounds, and when there is no peripheral or local evidence of impaired circulation, and fatty degeneration and myocarditis are absent, disturbances in rhythm, either an increase in rapidity, or slowing of the heart's action, even irregularity and intermittency, are not of necessity evidence that compensation is rupturing or ruptured, even if marked murmurs be present. The fact of the co-existence of functional with organic disease is of vital importance, both therapeutically and prognostically. Symptoms and signs, therefore, referable to the heart as a vital organ, are not of necessity of value, in a diagnostic sense, as indicating a rupture of compensation in valvular lesions. I make this statement in a broad, not in a restricted sense. Be careful, then, not to consider that all cardiac symptoms are due to a valvular lesion, if you discover it. A very little practice, indeed, will furnish the necessary data for discrimination in these double cases.

Another error frequently made by the general practitioner is a failure to examine into the condition of the heart as a vital organ during acute illnesses. In acute illnesses the heart far more fre-

quently fails as a vital organ, than as a result of previously existing disease, except perhaps in those diseases where pronounced degeneration of the cardiac structure takes place, and an absolute myocarditis supervenes. Perhaps a first examination is made, and no gross organic disease being discovered, the heart is thereafter neglected, or the radial pulse is carelessly interrogated. The radial pulse is by no means a criterion of the condition of the heart as a vital organ. Your findings at the wrist are simply suggestive. The radials are subjected to the variations of arterial tension, and an examination may give you a fair idea of the condition of the arterio-capillary system, of the condition of the coats of the artery, of the conditions of tension, but most certainly not of the actual condition of the heart itself. The radials may be relatively full and yet the heart be failing. The pulse furnishes corroborative, but not conclusive, evidence. Cardiac failure in acute diseases could often readily be averted if the first changes in the cardiac sounds and intervals were noted, and the significance of the modifications taking place in them understood.

In examining to determine the size of the cavities of the heart, if you expect to make fine distinctions you will be greatly mistaken. Many of the delicate text-book hypertrophies and dilations are pathological differentiations discoverable post-mortem, and are practically not diagnosable during life.

It is within our province to determine the existence of hypertrophy, of dilation, or a preponderance of either, of valvular lesions, and sometimes of fatty degeneration and myocarditis, and also to determine, in most instances, the vital vigor of the ventricular walls, *i.e.*, the strength of the heart as a muscle, and its capability of performing its work as a pump.

The signs of enlargement are easily obtainable. The differentiation between hypertrophy and dilation is made largely from factors furnished by the character of the cardiac sounds and the force of the impulse. Where no impulse is detectable by inspection from in front or side, I have sometimes been able to locate the seat of the apex beat by looking from below upward. In determining the force of the impact of the heart against the chest-walls, after failure by the usual methods of palpation I have placed the patient in a knee-chest position, and have made my observa-

tions with the stethoscope. I have succeeded in some instances by placing the patient well on the left side, the position naturally displacing the apex beat outward, and have thus been enabled to judge of the force of the heart's impact. The force with which the heart strikes the chest-walls is of importance in determining the state of the heart as a muscle. Concomitant evidence of weakness must also be furnished by other signs. The force of the impact is only one factor.

It must be remembered that grave dilatation of the heart can exist when a considerable muscular element is noticeable in the systolic sounds. Frequent previous examinations are of extreme value in determining the real weakness of the heart. Where I have been in the habit of making frequent examinations in individual cases, I have been enabled to detect serious dilatation, although the heart sounds, compared with another individual's, might apparently be indicative of a fairly compensating hypertrophy, or of good muscular power in the organ. Even in first examinations, by carefully noting the manner in which the heart acts, and the concomitant evidence offered by changes in the second sounds of the heart, the alterations in the intervals, together with symptoms indicating cardiac failure, save in very exceptional cases, there is little difficulty in determining the exact state of the heart. I have noticed this apparently considerable amount of the muscular element of the first sound, especially in hypertrophies, with dilatations, secondary to such lung lesions as emphysema and fibroid phthisis. In one case of emphysema, with general dropsy the result of secondary cardiac failure, the pulse was full to the last.

Another point to which I wish to call attention is cardiac pain. The impression left by the perusal of the text-books is that pain is almost totally absent in organic heart disease. So universal is this belief that the conclusion is not infrequently drawn that the presence of pain (excluding, of course, angina pectoris, which may or may not be associated with detectable organic disease) argues in favor of a disease being functional in character. Indeed, some physicians use this supposed fact as possessing diagnostic value in differentiation between organic disease and inorganic disease. I must protest against the further propagation of this error. Organic

heart disease does cause decided pain, not anginal in character, in so large a number of cases, that the assertion of the text-books is rendered valueless. At least, so my experience speaks. While not very frequent, pain is often enough complained of in cases of organic heart disease, to render the diagnostic conclusions drawn from the presence or absence of pain valueless. I have been careful, in the organic cases characterized by pain that have come under my observation, to eliminate pleurodynia, intercostal neuralgia, myalgia, gaseous distension of the cardiac end of the stomach, and other possible sources of error.

Let me briefly summarize the principal points I have attempted to make:

1. Pathological and physiological knowledge is insufficient for diagnostic purposes.

2. The heart must be studied as a pump and as a vital organ, from a psychio-physical as well as mechanical standpoint.

3. The transmissions of cardiac murmurs are not always typical.

4. Organic murmurs are not invariably constant.

5. Organic murmurs are not always exactly synchronous with the heart sounds or intervals.

6. The points of maximum intensity in are not invariably typically placed.

7. Organic murmurs often vary in intensity, the variations sometimes being significant of beginning dilatation (when the intensity becomes diminished,) and sometimes not.

8. Concomitant evidence (alterations in valvular sounds, etc.) is in some cases quite as conclusive of the existence of valvular lesions as the presence of a murmur.

9. In rare instances a murmur may be absent when valvular disease exists.

10. A murmur heard during palpitation of the heart may not be organic.

11. A blurred heart sound is suggestive of the existence of a murmur, asynchronism or slight reduplication.

12. A murmur heard during acute diseases of an adynamic type is not of necessity evidence of the presence of acute endocarditis.

13. The radial pulse is an unreliable guide as to the condition of the heart itself.

14. Grave dilation of the heart may exist with a considerable muscular element observable in the first sound.

15. The modifications that occur in the cardiac intervals are of great value in determining the condition of the heart as a pump.

16. Organic and functional heart disease frequently co-exist.

17. In order to exclude valvular lesions the subject should be examined while lying as well as while standing.

DISCUSSION.

Dr. Korndœrfer agreed with the author in a measure, though he thought that the doctor had gone too far in his assertions. It is possible to examine the condition of the heart perfectly while the patient is in a standing position. He has often done it. He always taught his students to go to a distance from the heart location as pointed out in the text-books. We must do it, because where we have any consolidated lung tissue, the sounds are conveyed beyond the points indicated on these charts. He endorsed very strongly the use of the stethoscope as compared with the ear, believing that finer distinctions can be made, and sounds heard which cannot be heard by the ear.

Dr. J. L. Ferson commended Dr. Snader's recommendation that, in listening to heart sounds the ear should be kept close to the chest quietly for a considerable time, so that we may become accustomed to the chest sounds, and thus we can get the heart sounds better.

Dr. Dietz wanted to know if any points could be given by which we might determine whether the sounds are due to a heart deficiency—an organic lesion. He remembered one case in which there was a mitral regurgitation, simulating an organic murmur. The sound was very strong, and there were present a number of indications of organic heart disease. In every other respect the patient is now well, but the murmur still exists.

Dr. Snader, in reply, said that Dr. Dietz's case had undoubtedly a compensated valvular lesion. He also said that organic disease of the heart can exist without giving rise to special symptoms. An organic lesion can exist and be compensated for so as to give rise to no symptoms whatever except those arising when the organ is subject to great strain. In pernicious anæmia, a

murmur does exist and seldom entirely disappears, because the condition giving rise to the murmur is not recovered from. Where there are no other particular symptoms of a rupture of compensation, a person with an organic murmur need have no fear if he lead a fairly quiet life. A great number of murmurs can be found without any definite history of diseases liable to cause them. He gave it as his opinion that the muscular form of rheumatism, where the joints are not involved, may be followed by heart trouble. He had seen a number of instances apparently corroborating this view. He thought, too, that during the next ten years the description of endocarditis, its prognosis and clinical phenomena, would have to be entirely rewritten.

EXCESSIVE MEDICATION.

R. P. MERCER, M.D., CHESTER.

"WHERE a little is good, much is better," is an old, and to the unthinking and uneducated mind, an incontrovertible fact; but when applied to medicine, to Homœopathic medicine in particular, it needs no argument and but little observation to prove the fallacy of any such impressions. Indeed, if we were to judge alone from the pages upon pages that have been written upon dilution, attenuation, dynamization and the single dose, we would be inclined to reverse the saying and teach that as a little is good, less is better.

But the object of this paper is not to establish the truth or untruth of either the one or the other, but to call more careful attention to what must have been the observation of all observing Homœopathicians, viz., that when an impression has once been made upon the case under treatment, a medicinal action observed, the dose should no longer be repeated while that medicinal action continues, at least.

The more closely the case is covered by the remedy, that is, the more nearly to, and in accordance with, the Homœopathic law, *similia similibus curantur*, the remedy has been selected, the more

absolutely necessary does it become, after the first impression has been obtained, to wait until the dose shall have spent its force; and if you are a low dilutionist—as I suspect you are, or this paper would not have been written at this time—the more imperative does the observance of this rule become. Take a case in point. You are called in the evening. It is influenza, or la grippe. The patient is suffering severely—just taken, but looks like being a bad case. Aconite is the similimum. You leave it in water, to be taken every hour. Next morning your patient is better; less fever, skin moist and the pains much more bearable. You are elated, and in the exuberance of your joy you repeat the dose and drive to the next patient. On the following day there is little or no improvement, but aconite started off so well it is again repeated, and you return to find your patient with more fever, weak and exhausted, aching, discouraged and dissatisfied with both you and himself. Haven't you found it just that way? Some of you have, I think. I know I have, and my patients have been days and sometimes weeks before they recovered, treat them as best I could afterwards.

On the other hand, in almost identical cases, I have stopped all medicine after improvement has set in with the first prescription, and a prompt cure has always followed on about the third or fourth day.

Take another case. Let it be diphtheria. You select mercurius iodatus rubrum, second or third trituration. When you call again in the course of twelve hours the symptoms are satisfactory, and you continue the remedy. The next day the child is a little better; the severity of the symptoms seems to have subsided, and the membrane is not so glairy. It has quit spreading and is beginning to loosen a little around the edge. This gives you courage. The powders are continued, and, perhaps, repeated a little oftener, in order to hurry up things; and it will hurry the membrane to peel off, it may be en masse, but it has left a bad throat; a bad case.

Medicinally poisoned and enfeebled, the second state of that child is worse than the first. And if it does not die within the next few days or weeks, it may live to wish it had.

But, stop the mercury within the first twenty-four hours, or as

soon as the medicinal impression has been observed. Most decidedly stop when the membrane has quit spreading and has begun to show an edge, which it soon will do if mercurius iodatus has been properly selected, and it very often is the remedy. Stop all medicine right here and the result will be most satisfactory.

My experience has fully convinced me that much of the mortality, and more of the prolonged suffering, in diphtheria, is caused by too much medicine, even among Homœopathicians, and I am not usually classed amongst the high attenuationists either, although that may go without saying.

Not long ago, a prominent Allopathic physician asked what medicine would be Homœopathic in the case of his daughter, who had been suffering for a long time without his having been able to relieve her in the regular way. After giving a very full and clear statement of her symptoms he was told to give her arsenicum, third trituration, which he did. In a short time he reported that she had improved very much for a time and then come to a standstill. He was told that he should have stopped the medicine. He saw the reason at once, wondered why he had not thought of that himself. He stopped the medicine and she got entirely well.

Many other cases might be cited in illustration, but it is entirely unnecessary. We all recognize the fact that if we are to cure a train of symptoms with a drug that will produce the same symptoms, the dose must not be large nor repeated. This is a fact that needs no argument. The conclusion is so rational that it is axiomatic. Why, then, is it that we so often fail to practice according to the rule of the minimum and the single dose? Is it because of an innate superstition that continues to cling to us, with an anxiety to heal more quickly, that we continue to practice according to the old and irrational dogma, that where a little is good, much is better?

Whatever the reason may be that we do not, there is great necessity for us all to practice more carefully what we know to be one of the first and most important requirements of Homœopathy.

This has been repeatedly urged upon us by the highest attenuationists. It is one of their strong points, never to be neglected. And why, if we use the lower dilutions, because we require a

stronger drug action, should there not be even greater necessity for our observing the rule?

There undoubtedly is. And if we are going to allow ourselves to repeat the well-selected remedy, hour after hour, and day after day, the sooner we adopt the high attenuation theory the better it will be for our patients, ourselves, and for Homœopathy.

DISCUSSION.

Dr. Dietz: The doctor endorsed the paper, saying that it embodied his experience. The longer he practiced the more was he convinced of the truth of Homœopathy. Generally, in the earlier years of his practice, he alternated his remedies, and it was the exception for him to use high potencies. As time went on, he began to use the single remedy, and this became finally the rule rather than the exception, until to-day he rarely uses two remedies. Nor does he repeat the dose when he gets an improvement. In one case which he called to mind he destroyed all chance of a cure by giving too many doses. The case was one of asthma of a very aggravated type. After giving a number of remedies, in different potencies, he finally gave one dose of lycopodium 26m. Considerable improvement was noted inside of a week. Three weeks afterward, in order to make a good action better, he gave a few more doses, with the result of "knocking out" the case. He never could do the patient any good after that.

Dr. Van Artsdalen called attention to the fact that a great many remedies will not bear repetition, while from others we can not get any action from a single dose. Then, too, some remedies in their action run a course of one hour, others have an action which is perceptible at the end of a week. To give one dose and stop in all cases is wrong. For example, take arsenic. We might rely upon it after giving, say twenty doses. Then give another dose, and in six hours it may be found in the lacteal secretion. Iodine has a similar action, but here the period of time which elapses between the taking of the dose and its appearance in the secretion is three days. Arum. triphyllum and argentum nitricum are similar in their action. With such remedies a single dose would, perhaps, do the work.

Dr. Dietz called attention to the fact that the chemical and

the dynamic actions are two entirely different things. His only point was that, after improvement has set in, we should stop giving the remedy. Because we cannot find iodine in secretions after a certain period, is no reason why we should believe it has stopped its action.

"PURPURA" RHEUMATISM.

C. VAN ARTSDALEN, M.D., ASHBOURNE.

Mr. C———, no occupation, aged twenty-three, has suffered from rheumatism since sixteen, sometimes of joints and sometimes of muscles, and occasionally has stiff neck. He avers that he is never entirely free from pain. For about three years past the trouble has been mostly muscular. Following each attack, as the slight œdema of the legs begins to modify, bright colored patches about the size of ten-cent pieces appear, gradually getting darker, until it became a greenish purple, when the pain would reach a condition of half comfort. After about three to five days the dark color changes to a greenish-yellow, then to that like an ordinary bruise; then the spots gradually disappear, waiting for a renewal of the rheumatism before they show again. These attacks are unaccompanied by any marked general symptoms.

The symptoms of rheumatic purpura are fairly well defined, yet different authors have held that there is no such malady. Some say rheumatism, others call it purpura, others erythema with an accompaniment of pain in the joints and cutaneous hæmorrhages. Schonlein and Hebra, as early as 1829, recognized this as a distinct disease. Most German writers, including Fuchs, think it closely allied to rheumatism, but different in its nature, independent of either purpura or erythema. Wunderlich thinks it a variety of purpura, and so with others. Are we justified in naming it rheumatic purpura? We have the inflammation, pain, and recurrence of rheumatism, and the purpuric spots, with slight constitutional symptoms, pain, redness, and swelling of joints, with purpuric spots after a few days, then the symptoms disappear and the patient is well. I can see no other name with which to properly designate the condition.

IS DIPHTHERIA CONTAGIOUS?

JOSEPH E. JONES, M.D., WEST CHESTER.

SEVERAL years ago I made an extended report of many cases of violent diphtheria, where they, having run through their courses with great seriousness, and constant exposure to outside persons, yet the exposed subjects showed no symptoms of contagion generated by simple contact. My present purpose is only to supplement that former statement, in order to bring other cases to verify the fact, that where the persons are not subjected, all alike, to the action of the virus, or the cause of the diphtheria, there is no disposition to take the disease by *mere* contact.

Then I defined the difference between contagion and infection. While we all acknowledge that diphtheria is infectious, the question to be settled is, "Is it contagious?"

Bear in mind that contagion is from the word *contagio*, meaning "to touch together," and that the word "infect" means the same as the root from which it is derived, *inficio*, "to thrust into." It is with these meanings that we wish to designate the difference.

It has been ten years since the article above referred to was written. All that time my attention has constantly been given to the question under consideration—"Is Diphtheria Contagious?" With frequent opportunities for observation, and repeated cases where the disease could demonstrate its contagious character, I have, as yet, seen nothing that has in the least changed my conclusions in that paper, namely, that "diphtheria is not contagious."

Let me rehearse a case that but recently came under notice. Three children of the ages of two, four, and six, resided in a Western city, who, with their mother, were to start for the East in a few days, when the oldest boy was taken with symptoms of what was then pronounced "a bilious attack" The indications that pointed to this kind of an "attack" were great weakness, high fever, sick stomach, sore throat, enlargement of the glands on each side of the neck (which the physician in attendance said was produced by vomiting), offensive breath, heavily coated tongue. The parents, though alarmed at the sickness, were

calmed into security by the diagnosis of their physician, *who had not looked into the child's throat.* They started on their journey East, requiring two days and two nights in the same sleeper, where there were no less than twelve other children, of various ages. The child during the journey was terribly sick, extremely prostrated, and the enlargements at the sides of the neck became very great. I saw the case an hour after it arrived at its place of residence in the East, and it was then a most fearful case of diphtheria, with symptoms of diphtheritic croup, which soon fully developed. It is not our desire to follow the case, but to call your attention to the effect of the diphtheritic poison on the other children, who were forty-eight hours in the same car. So far as we can hear, not one of them was influenced by the "contagion" around them. This was a long-continued and very intimate exposure, with and around the little sufferer, and, think of it, for two days and two nights, virtually in the same room, living and sleeping.

Again, there were four young persons who attended this case as nurses, living and even sleeping in the room, and none of them were attacked with the disease. They had never had this affection, and even if they had, it is generally conceded by the profession that one attack does not prevent another, but, in fact, predisposes to successive ones. Physicians seldom take this disease, save it is by infection, or "injecting into," which is so easily accomplished as the physician is examining the throat, the patient coughing or vomiting the infecting matter.

The one question we hear asked most frequently by those who are advocates of the contagiousness of this disease is, "How is it that it goes through all the members of a family?" The answer to that is, indeed, very easy, as all the members of that family are exposed to the same generating cause.

In a large boarding school, containing over two hundred scholars, the diphtheria was prevalent, cases filling the nurseries successively; but when the cause was found and corrected there *were no new cases,* which there would have been if it was produced by contagion. Surely, if the cause was "contagion," the whole school would have been contaminated with the disease. So we might go on with a much longer list of instances to prove the truth that diphtheria is not contagious.

LEUKÆMIA.

J. RICHEY HORNER, M.D., ALLEGHENY.

THE case which called my attention to this form of disease was one which baffled several physicians in regard to a diagnosis, and it was only a few months previous to death of the patient that it was finally determined as to its nature. Numerous reasons were given for the development of the condition, as will be seen in the history which will be given. In searching for a description of this disease and that of the more common one, pseudo-leukæmia, but little was found, and in Homœopathic literature practically none. Why there should be this paucity of information is hard to determine, unless it be that the disease is a rare one. In conversation with several physicians who have been in practice for a number of years, the writer was not able to find one man who, in the course of a practice extending over periods varying from twenty to forty years, had seen more than two or three cases. Then it was that the idea came that we should write up the case and preface it with a *résumé* of the literature on the subject.

Leukæmia is defined by Professor William Osler, M.D., of the University of Pennsylvania, in his very able contribution to Pepper's *System of Medicine*, vol. iii., p. 908 *et seq.*, as "a disease characterized by a great and persistent increase of the colorless corpuscles of the blood, associated with enlargement of the lymphatic elements, the spleen and bone marrow."

Our knowledge of the disease dates back only forty-five years, at which time the condition of the blood was supposed to be due to suppuration. Virchow shortly afterwards grasped the idea that the altered condition of the blood was due to a superabundance of white blood-corpuscles, and through all the controversy which followed held to that belief, and it was finally accepted and the name which he had given the disease recognized as a proper one.

Of the ætiology of the disease but little is as yet known, though many factors may be noted as influencing its production. It is more common in temperate regions; it is more common in the

middle period of life, though cases have been noted in rare instances both early and late; it is more often found in males; it is found in the lower and middle classes more often than in the higher; it follows, in some instances, periods of mental depression and worry; it has no especial connection with history of previous disease, except, very possibly, with a malarial history; it is connected at times with the occurrence of an injury, a blow or strain; but, aside from these possible predisposing causes, the ætiology is very obscure. Even a study of comparative pathology has not thrown light upon the subject.

The mode of onset is insidious. First is noted a failure of strength; an inability to accomplish work which had previously been done with ease. Derangement of the digestive system is perhaps the first serious symptom noticed. A profuse and persistent diarrhœa may develop. The nervous system is affected, and attacks of headache, vertigo and fainting are common. The mental sphere is not disturbed and sleep is not usually interfered with. Weak vision is often complained of, due to a retinitis, while deafness has been frequently observed and may appear early.

In diagnosing a case the microscope comes into play, and where at all practicable should certainly be utilized. The red blood-corpuscles are but little reduced in number, while the colorless disks are enormously increased, though it is not thought that they exceed the red in number.

The pulse is always rapid—80 to 100 in the first stage and as high as 130 later. Heart murmurs are not so frequently found as in anæmia, though the systolic murmur may be present. Owing to the enlargement of the spleen, the apex of the heart is often higher by an interspace than normal.

Respiration is interfered with, both as a result of the anæmic condition and of the splenic enlargement.

The temperature at first is but little affected, but later rises up to 103 or higher.

Hæmorrhages may occur at any time from the nose, or even the bowels or kidneys.

The urine is practically normal in amount, strongly acid and of high specific gravity.

As noted above, the spleen becomes much enlarged, and it is his condition which often first calls the attention of the patient to himself. The increase of weight causes a sense of dragging in the left hypochondrium, and usually its outlines can be readily mapped out by palpation and percussion. This organ may be enormously increased in size, one record of eighteen and one-half pounds being noticed, and it causes distress after eating, and may even compress the intestines and cause obstruction.

The lymph-glands are only slightly involved, this being one point of distinction between the disease under review and pseudo-leukæmia (Hodgkin's disease). There may, however, be enlargements of these glands, and when this is superficial, it is of course easily detected; but the glands must be of considerable size when deep in order to be demonstrated.

With regard to the condition of the bony system, little need be said, as but little can be determined. The bone marrow may be extensively diseased and show no indications of it, or there may be pronounced symptoms of trouble in the bone and but little real cause for it in structural changes.

The morbid anatomy presents a wide field for investigation. The body is usually much wasted. All the blood is coagulated and fills completely the heart and vessels, having a pus-like, greenish appearance. The heart is higher than normal and the spleen much enlarged, though retaining its normal shape, and weighs, on an average, say seven pounds.

In the lymphatic glands the hypertrophy is not so excessive as in Hodgkin's disease. The cervical, axillary, mesenteric and inguinal glands are most often affected, and when the swelling does occur it is to the size of a walnut, the tumor being soft, isolated and movable under the skin. Suppuration rarely occurs, and the surrounding parts are rarely involved.

As indicated in the definition, the bone-marrow is subject to quite serious changes. Here degeneration takes place, and the whole contents of the bone may assume the character of dead tissue, similar to that which forms the core of an abscess.

The stomach is but rarely affected beyond the presence of a catarrhal condition, while in the intestinal tract there may be tumors which have originated in the glands of Peyer.

The liver is enlarged, but retains its normal shape. This organ has been known to weigh thirteen and a half pounds in one case. The substance is usually firm and of a grayish-brown or even marbled color. Fatty degeneration is a common occurrence.

The respiratory system is not often the seat of important lesions. The kidneys do not undergo any important changes, though here, as in all the other organs, there is enlargement, with a distension of the capillaries with leucocytes.

The course of the disease is slow and chronic, lasting through months or years. During this course periods of improvement occur, and may lead to the belief that a cure has been effected. Oftentimes hæmorrhage may shorten the course, or the high fevers, profuse diarrhœa, or dropsy. In the majority of cases death is by asthenia.

The diagnosis is difficult, and unless a microscopic examination of the blood has been made, and the increase in the number of the white corpuscles positively shown, it is impossible to diagnose it with absolute certainty. There are three diseases which it simulates: (1) chronic malarial infection, with splenic hypertrophy; (2) non-malarial splenic enlargement, with anæmia; (3) general lymphadenoma, or Hodgkin's disease. In the first, malarial history, absence of lymphatic enlargement, and condition of the blood will differentiate. In the second, about the only sure way is to examine the blood microscopically. In the third, there is still greater difficulty (and just here I may say that while I have characterized the case which came under my observation as leukæmia, in the absence of the proof of the microscope, I am not absolutely positive that it was so). In Hodgkin's disease, the glandular enlargement is usually greater and more prominent, and the spleen not so large.

The prognosis is in the highest degree unfavorable. Temporary improvement may occur for a time, but this is usually very transient.

Of the treatment, not much can be said. Grauvogl recommends natrum sulphuricum and thuja as the main remedies, while Raue says that remedies of the hydrogenoid order may be indicated by special symptoms.

The case which came under my care was that of F. L., aged

forty-seven, male. The family history is one of scrofula and tuberculosis. One sister died of the latter, and an elder brother has "white swelling," affecting the knee-joint. The personal history of the patient had always been good up to the early fall of 1887. He had had only one sickness during his adult life (that of typhoid fever at the age of twenty-seven), and had always been a hard worker, being a farmer conducting the affairs of a large estate.

About the time of his first noticing any symptoms, he had a great deal of domestic trouble, and at one time his physicians thought his condition due to poisoning. This latter theory, however, was afterwards abandoned.

The first symptoms noticed were gastric. There was flatulence, metallic taste, nausea, and loss of appetite. His general health began to fail. The next spring he had a very severe attack of what he called cholera morbus, which lasted for some time. Two years later he had la grippe, and from this time his strength failed quite a pidly. He complained much of vertigo, and became quite nervous. He was much worried about his domestic affairs; could think and talk of little else. During this summer the lymphatic glands became much enlarged—those of the neck, both sides, the groins, and axillæ. There was much dyspnœa, and a great deal of distress in the region of the heart—palpitation, etc. He became much jaundiced, the liver and spleen were enlarged, the kidneys inactive, and the bowels constipated.

The swelling of the lymphatics continued for about nine months and then disappeared. During this time the principal remedy given him was iodide of arsenic, and he seemed to improve perceptibly. The dyspnœa, however, continued, and there was a progressive weakness which belied all hope of curing the condition.

In the absence of daily notes (the patient lived fifteen miles out in the country, and I saw him only twice a week), I am unable to give a detailed history of the case. Death ensued in July of this year from asthenia.

FIFTY CONSECUTIVE CASES OF TYPHOID FEVER.

M. M. WALKER, M.D., GERMANTOWN, PHILADELPHIA.

THE cases here reported were treated carefully for a few days, after the onset of the first symptoms, before the diagnosis of typhoid fever was made, and were then reported to the Board of Health.

They all had the characteristic symptoms of tremor of tongue and limbs, the typhoid or "smoky" condition of the intellect, roseola, sudamina, diarrhœa, nose-bleed, cough, evening rise and morning fall of temperature, delirium, tympanites, etc.

I shall endeavor to show the duration of the disease from the first visit to convalescence, the pulse, the highest temperature, and the principal remedies, or the wonderful action of the properly-indicated remedy according to *our law of cure.*

The single remedy has invariably been prescribed, except where mention is made otherwise.

Meat, or soups containing meats of all kinds, have of late years been prohibited until the temperature reaches to normal in the evening. Milk, vegetable tea, orange-juice strained, unfermented grape-juice, lemonade, and pure water have been used in satisfying quantities.

Where the temperature rises above 104° F., I generally made two visits daily. I leave a thermometer (and sometimes two) in order that a strict record may be kept, especially where people are in moderate circumstances, and desire but one visit daily.

Trained nurses I regard as one of the greatest blessings ever introduced into the sick-room. The patients are generally charmed with their attention; the physician feels sure of their oversight of his case; and their hourly reports are a source of comfort when a patient is safe, and show their vigilance where serious symptoms are about to set in.

These patients were treated from August, 1878, to June, 1891, excepting the years 1880, 1882, 1883, when I had no cases of typhoid fever.

CASE 1.—Lemuel N.; about twenty-two years old; August 29th to October 19, 1878; fifty-three days; pulse, 88 to 100; highest temperature, 104.5° F., on the third day. It gradually lowered to 98° F. on the seventh day, when it rose again to 104° F. in the evening, and remained there for three days. Bryonia was the first remedy, and rhus toxicodendron when the temperature rose again. Lycopodium did good work for several days, when rhus toxicodendron seemed to be again indicated. On September 11th, for symptoms which I did not record, natrum sulphuricum was prescribed; and later, for persistent malarial symptoms, nux vomica and china were given.

CASE 2.—Percy C., a boy five years old; January 1st to February 2d, 1879; thirty-three days. This case began as gastric fever and merged into typhoid. The temperature was 103° F. in the morning, and 104° F. in the evening of the second day of attendance. On the third day, roseola appeared on the abdomen, and we found, on tracing the history of the preliminary symptoms, that the boy had been ill about nine days. After this the case took the usual form of typhoid, the morning temperature being about 102° F. and 103° F., and a fraction in the evenings for another week. The pulse ranged from 104 to 120. The remedies prescribed were, first, sulphur 600, then lycopodium 200. The action of the last was continued one week. I was then ill for eleven days, when a colleague took charge of the case for me. On January 25th, for feebleness of the heart's action, I gave veratrum viride. The boy took cold January 28th, and aconite, spongia, and belladonna were given in turn for three days, when rumex crispus 200 cleared up the laryngeal trouble and convalescence set in. The probable cause of this case was sewer-gas coming up through the stationary wash-stands, which were in nearly every room of the elegant mansion in which the patient was ill.

CASE 3.—James P., eighteen years; October 1st to November 15th; 46 days. Nosebleed was a prominent symptom. Temperature, 104.5° F. on the third day. Bryonia 200 was given. The temperature lowered to 103° F. on the fifth day, from which time it gradually became normal. For subsequent nervousness hyoscyamus 200, and, later, sleeplessness called for opium 200. On

October 14th, lachesis 200, then bryonia. The nervousness came on again, so that on the 22d he received opium again. For malarial symptoms, china, and also natrum muriaticum, were given during the third week. He then took cold, and on October 26th a congested right lung was found. Bryonia 200 was given for the cold, and, later, sulphur 6m, morning and evening, and phosphorus 6x every two hours for the pneumonia. The pains and stitches continued, and kali carbonica 6x was prescribed with benefit. On November 1st he received bryonia 30th, and on the 4th kali carbonica 45m. The sleeplessness reappeared later, which opium again relieved. China was given during convalescence, and by November 15th he was well.

Case 4.—Rebecca P., eleven years; August 10th to 31st, 1881; 21 days. Pulse, 100 to 112. Highest temperature, 104° F. The parents of this child lived in a house which was in a row of residences where the odors of eighteen out-houses, with wells, were wafted through the doors and windows every moment of the twenty-four hours. She became exceedingly nervous and was sleepless day and night. Arsenicum 200 appeared to do her some good, but did not seem to be the correct remedy. On consulting the materia medica, hyoscyamus was found to have similar symptoms. The 200th was given every hour, with magical effects, and in a few days she was sitting up.

[The family in which this case was ill subsequently moved to a farm, where cases Nos. 11, 12, 13 and 14 occurred.]

Case 5.—Henry T., twenty-eight years; May 7th to June 10th; 34 days. Pulse slow, 80 to 90. Temperature, 101.4° F. The family used spring-water, which was probably contaminated. Arsenicum 200 was his principal remedy. This man recovered slowly, and died two years later from apoplexy.

Case 6.—Sarah C. W., aged two years; February 14th to April 14th, 1881; 60 days. Our little daughter, and the youngest case I ever had, was taken ill on St. Valentine's day, and went through all the various stages of the disease according to the description in Professor Raue's *Pathology*. Sewer gas found its way into our cellar from the house adjoining, and, contaminating the milk as well as the atmosphere of the house, was the probable cause. A light case of fever

occurred next door, and when the workmen dug out their kitchen cellar afterward, they were frequently overcome from the odor of sewer gas in the soil, this fact showing defective drainage. No one but an anxious parent knows the anguish one suffers as they see their dear, little, helpless child go through all the various stages of this disease with scarcely any mitigation. The fourteenth, twenty-first, and twenty-eighth days passed by. The delirium grew worse; the diarrhœa continued. Our darling grew thinner and thinner; her hands and feet felt dry, and were more like the claws of a fowl than the extremities of a child. In her nervousness and delirium she would scratch us like a bird of prey. I looked up her case and gave her arsenicum, lycopodium, hyoscyamus, rhus toxicodendron, baptisia, and other remedies, but all were of no avail. My parental anxiety overcame my professional judgment, and I felt helpless, with but a slender cord between life and eternity for our lovely child. I then called in the noble Farrington, who sat down patiently in my library, and studied out the case faithfully and religiously; when I reminded him that it was getting late and that trains would not wait, he said: "Never mind the trains; let us find the remedy." At length he said it is either chamomilla or coffea. I had not thought of either; but as I read the symptoms it was chamomilla beyond a doubt. The third decimal was given in water every hour. This was on the 7th of April and the fifty-second day of her illness. Next day, and not till then, did improvement set in. I think in our anxiety and endeavors to find the proper remedy, we look too far into the beyond for something great or unheard of, and seldom used, when we should read and reflect, and often select the simple and familiar similar, as chamomilla was in this case, a proper messenger under the Homœopathic law of cure. Three weeks later, our daughter being convalescent, I went on a pleasure trip to California, and on my return, in June, I found our little one as plump and happy as a child could be. I have never forgotten to bless the name of Samuel Hahnemann for his glorious law of cure, nor to praise the name of the since lamented Dr. E. A. Farrington for his persistent endeavors to save our child.

Case 7.—Miss Jennie T. M., seventeen years; July 16th to

August 15th; thirty days; pulse, 96 to 104; temperature, 100.5° F. This case began more like spinal meningitis, and may have been caused by a suppressed eruption from taking swimming lessons. The symptoms took on the typhoid form and the case was pronounced to be typhoid fever by Dr. Ad. Lippe, the consulting physician. Rhus toxicodendron 200th was the principal remedy.

Case 8.—Miss Alice U., seventeen years; January 26th so March 7th, 1885; forty days; pulse, 100; temperature on fourth day, 104° F., which continued every evening till the eighth day, when an alarming nose-bleed set in, which lowered the temperature to 101° F. The fever rose afterward to 103° F. The remedies used were rhus toxicodendron, baptisia, arsenicum, antimonium crudum, carbo vegetabilis. After the epistaxis subsided diarrhœa ensued, when lycopodium 200 was clearly indicated and proved to be the proper remedy all through the case. Although this young lady was very ill, the nose-bleed, in lowering her temperature, was a blessing in disguise. The diarrhœa which followed, I think, helped to keep the temperature down, and, instead of having a patient wild with delirium, she quietly and safely floated through the attack to convalescence, aided by the lycopodium and good nursing.

Case 9.—Mr. Charles N., about twenty-two years; July 29th to September 7th; forty days. He began with a pulse of 80, headache and abdominal symptoms. On the eighth day his pulse was 96, his morning temperature 102.5° F., and in the evening it reached 104° F. He had slight nose-bleed for several days and considerable diarrhœa for two weeks. Bryonia was given at first, but rhus toxicodendron was the principal remedy throughout the case.

Case 10.—Harry R., nineteen years; July 8th to September 11th; sixty-five days. This youth began with a severe headache, both frontal and occipital. His pulse ranged from 96 to 100; respiration 32 to 40; and the temperature, at the highest, registered 105.5° F. At the time of taking the temperature the thermometer registered 104.5° F., but was found afterwards to register one degree too low. This was a very important and persistent case, showing how thoroughly the system is poisoned by the typhoid

germs, in which weeks go by with scarcely any improvement. On July 19th there was retention of urine, and the catheter was used. On August 3d a hæmorrhage from the bowels occurred. The patient was so low that I stayed with him all night for ten nights. On August 19th the pulse was 76, the temperature normal, and we hoped the patient was convalescent. He disliked milk, and his food was a very important consideration. On August 24th we allowed him to eat beefsteak and vegetables, in consequence of which he had a relapse—the temperature reaching 104.5° F. Rhus toxicodendron 200 was now the principal remedy, although during his illness it was very difficult for either the consulting physician or myself to decide upon the proper remedy. On September 11th the pulse was 76, the temperature normal in the morning and in the evening the pulse was 84 and temperature 101° F. The consulting physician came from Philadelphia (ten miles) thirty times during this illness, and by the display of an art known to few men in the profession, this case passed entirely into his hands, and so continued to complete recovery.

Case 11.—W. P., thirteen years, a brother of Case 4; September 25th to October 20th; twenty-five days; pulse, 88 to 112; temperature, 105° F. The fever probably began on September 20th. During the first week of attendance the temperature reached 104½° F. Nose-bleed and diarrhœa depressed the fever some, and, by the aid of Bryonia 6th, it ranged from 102.5°F. to 103° F. in the evening. On October 12th a relapse occurred and the thermometer indicated a temperature of 105° F. Natrum muriaticum 200 was given, afterwards China 6x, and the fever in one week more was gone.

Case 12.—Mary E. P., twenty years, a sister of the above, was taken ill October 28th, and so remained till November 16th; twenty days. Her fever pursued a moderate course; pulse, 88 to 100; temperature, 102° F. up to 104° F. Rhus toxicodendron was the principal remedy, with a few doses of baptisia and hyoscyamus for nervousness.

Case 13.—Anna P., nineteen years, also of the same family as the preceding case, was ill from November 23d to December 14th; twenty-one days. She had been indisposed for some days and would not give up that she was ill. Her temperature was 105° F.

on the third day and 106° F. on the fourth. She was very ill. Arsenicum was clearly indicated and acted promptly. The temperature lowered to 103.5° F. in one day, where it remained for three days, when 102° F. was indicated, with a pulse of 88. The fever then gradually subsided, and when she became restless and sleepless I gave her hyoscyamus, with as good effect as I did her sister in Case 4.

Case 14.—W. P., aged sixty-five; milkman, and father of cases Nos. 4, 11, 12, 13. He was ill from November 28th to January 15, 1887; forty-nine days. This man was not in good condition to go through typhoid fever, he having scorbutic gums, loose teeth, and was not strong. His temperature began at 101° F., rose to 103° F. on the third day, then under arsenicum 6x began to subside. Rhus toxicodendron, lachesis, and bryonia were given on different days, as the case required. On December 20th his pulse was 64; temperature, 100° F. There was depressed vitality from some cause, and a stimulant was given. On December 28th a hæmorrhage from the kidneys occurred, which yielded to nitric acid 6x. His pulse dropped to 54 on January 8th. He was very nervous, and hyoscyamus again came in to do good. This man was some months regaining his strength, as dropsy persisted as a sequela to the disease. This family, like many others, thought their pump water was about the best in the land, and, living on a farm adjoining the town, preferred this to the hydrant water at the owner's mansion close by. On inspection of the premises I found it possible for the drainage of the barnyard to find its way into the well. The summer had been very dry, and great cracks in the earth showed how it was possible for drainage to run toward the well. The water was analyzed and found "unfit for use except by boiling." The city water was subsequently introduced. This family sold their farm implements and moved away. At present writing they are all well, six years later.

Case 15.—Miss Florence McD.; thirty-one years; August 4th to 31st, 1887; twenty-seven days. This lady probably brought the germs of the disease in her system from Indiana, whence she came to visit her sister. Pulse, 92; temperature, 102.5° F. Baptisia 6x was the principal remedy, Nothing unusual occurred in this case.

CASE 16.—J. J. B.; a man of about thirty-one years; July 27th to September 10th; forty-five days. Pulse, 80; temperature, 102° F. He pursued quite an even course, with lycopodium 6x as the main remedy, till August 6th, when sciatica gave him much pain. Bryonia, and, later, pulsatilla helped. He then became nervous, and hyoscyamus was indicated. On August 12th severe pains in hip and calves of the legs occurred. Cimicifuga 6x relieved these. This patient was an overworked bookkeeper. He lost his hair and had his head shaved. He spent one week at the seaside, and resumed work at least one week too soon, in consequence of which he was several weeks regaining his usual strength.

CASE 17.—Miss Gertrude D.; twenty-four years; ill thirty-eight days. This young lady contracted intermittent fever at a summer resort, in New Jersey, which lasted from September 3d to October 8th. Typhoid symptoms then set in and continued till November 15th. Pulse, 100; temperature, 102.5° F. Lycopodium and china 6x were the principal remedies.

CASE 18.—Miss Nettie W.; twenty years; February 1st to March 7th, 1888; thirty-five days; temperature, 104° F. This case went through the usual course, with bryonia the first week. For cramps and cold extremities which occurred, veratrum album 6x, later, baptisia, and lastly, rhus toxicodendron, were required in the case.

CASE No. 19.—Miss Hattie T.; aged sixteen; a school girl; March 30th to May 7th; thirty-one days. This young lady started in, at least, when I first saw her, with a temperature of 103° F.; pulse, 105. She had nosebleed and diarrhœa. Her pulse rose to 112, and temperature to 104.2° F., in a few days. Lycopodium was the remedy which carried her to April 15th, when sulphur 6th was needed to cure up the diarrhœa. Convalescence followed, with nothing unusual afterward.

CASE 20.—Miss Bella W.; sixteen years; a school girl, with elegant surroundings in her home. She had the benefit of a trained nurse and the best attention possible. April 1st to May 1st; thirty days. On April 4th the pulse was 105; temperature, 103° F. There were present nose-bleed and diarrhœa. During the next three days the thermometer indicated 104.2° F., and

the pulse was 112. Lycopodium 6th was the remedy employed. The fever subsided steadily till April 10th, when the thermometer showed 103.4° F., then rhus toxicodendron was indicated. On the 19th nervous symptoms set in, with sighing. Ignatia was prescribed, and, later, while on a visit to Brooklyn, irregular action of the heart, with dyspnœa, manifested itself. On her return veratrum viride and pulsatilla, as indicated, with gentle exercise for a month, restored the case to normal health.

Case 21.—Harry F.; school boy; aged thirteen years; April 9th to 22d; thirteen days. Pulse, 96; temperature, 105° F. This boy was in his second week when I saw him. He had a red, dry tongue, with headache and bloodshotten eyes, for which I gave baptisia 6th, with wonderful effect. Rhus toxicodendron was prescribed later to finish up the case.

Case 22.—W. Y., a school-boy; sixteen years; April 15th to May 4th; twenty days; temperature, 102° F.; rhus toxicodendron. Nothing unusual occurred in this case.

Case 23.—Frank F., aged twenty-five years, married; August 10th to September 4th; then a relapse to October 4th; fifty-four days. This patient, at the age of ten years, had an attack of rheumatism, followed by endocardial murmurs, which he has had ever since. Pulse, 112; temperature, 104° F. Nose-bleed, nervousness and palpitation of the heart, with a blowing sound, were the principal early symptoms. His nose became so clotted with dry blood and clinkers that we used a douche to clear it. Sulphur, arsenicum, china, and aconite each had their share of symptoms to overcome. After recovering from typhoid fever, he was taken with congestion of the liver, followed by heart and lung difficulties, together with hæmorrhages from the lungs, etc. Dr. Malcolm MacFarlan was the consulting physician in this case. He prescribed strophanthus 20x for the mitral insufficiency and dropsy, and Carlsbad water 20x for the rheumatic symptoms, with excess of urea, dyspepsia, and mal-assimilation of food. Amyl nitrite 30 was also used for the mitral insufficiency. These remedies showed their action to a certain extent, but here was an incurable case. The patient moved to the healthful pine-belt of New Jersey, where he was more comfortable, yet succumbed to the inevitable a year or more later.

CASE 24.—Veryl J., ten years old; duration, twenty-five days. This boy was taken with cerebro-spinal symptoms, and remained unconscious several days. These symptoms were very alarming and decided from December 13th to January 11th, and yielded to sulphur, stramonium, opium, and cimicifuga, all of the sixth dilution. Typhoid symptoms then set in, and lasted from January 12th to February 6th. Highest temperature, 102.5° F.; pulse, 92 to 100. Arsenicum, lachesis, and china carried him through to convalescence, each given for their respective symptoms as they appeared.

CASE 25.—Horace C., a mulatto boy, ten years old; ill from January 7th to March 2, 1889; fifty-four days. This was one of the most persistent and trying cases I ever had. At the end of the first week his pulse ranged from 100 to 112, with a temperature of 103° F. in the morning and 104° F. in the evening, bryonia 6th being the only remedy. On the fourteenth day the patient was worse; the abdomen very greatly distended; the dyspnœa great, with mental apathy; he was silent and not able to move. I sat by his bedside and thought and studied out this case as though he was my own child, and found phosphoric acid to be the indicated remedy. I gave the 200th in water. His temperature in the morning was 104.5° F.; respiration, 48; pulse, 128. After hourly doses from 11 A.M to 6 P.M., the temperature was 104° F.; pulse, 128; respiration, 48. This showed a trifling improvement, although the boy looked as though perforation of the intestine would take place, and that he was near his end. The next morning the pulse was 112, respiration 32, and temperature 101° F. In the evening the temperature was 103° F. Then I saw there was hope. The next day he was decidedly better, although the morning pulse was 112, respiration 30, and temperature 102° F., while in the evening the pulse was 116 and temperature 103.2° F. I gave a little alcohol in water in place of phosphoric acid 200, and on the third day after the pulse counted 96 and temperature 100° F. in the evening. I continued the alcohol in water for a week, as this is a useful remedy alone in typhoid fever; then a few more doses of acid phosphoricum 200 were given, and convalescence set in. After the temperature came to 100° F., it did not rise again above 99° F. The pulse continued

at about 96. The boy scarcely uttered a word for three weeks, not even yes or no, and was turned from the side to the back at intervals, and, although perfectly conscious, he could not be induced to talk. Finally, he began to say a few words and to smile. The sudamina appeared so profusely on the fifteenth day that the vesicles and dead epidermis caused the boy to look very white and scaly for a week. I had had a box of very fine Florida oranges sent me, and took him some. He held one in his hand for two days, and looked so longingly at those on the mantel-piece that I allowed him to have the juice of one strained. The orange-juice agreed with him so well that afterward I allowed him the juice of two Washington or navel oranges daily. A little later I gave him unfermented grape-juice, two ounces at a time, four times a day. When the oranges could not be procured, he had lemonade made in this way: Three lemons, six tablespoonfuls of sugar, and one quart of water. The lemons should be pared if squeezed in a squeezer; but if pressed in the fingers, or over a glass cone made for the purpose, very little of the bitter oil, which is poisonous, will be expressed from the skin. No animal food of any kind was allowed him in soup or otherwise for a week after the temperature came to nearly normal. Milk and these fruit juices were kept at least an hour apart in their administration. Vegetable soup was given once or twice a day, and Poland water *ad libitum*. The cure of this case I consider one of the triumphs of Homœopathy, and phosphoric acid 200th did its work well. This boy recovered fully in mental and physical vigor, and two years later was accidentally drowned at Spring Lake, New Jersey.

Case 26.—Jos. J. D., sixteen years; January 13th to February 3d, when an aggravation occurred and the case continued to February 22d; forty days. The pulse was 100 and temperature 104° F. on the third day after I saw him. Bryonia was given for a week. At the end of that time the thermometer registered 102.2° F.; pulse, 90. Phosphoric acid 200 did not help much, but lachesis 6, a few doses, and then alcohol in water for five days, caused a subsidence of the fever. Then antimonium crudum 6, a few doses, was given, when china 6th came in to eradicate a few persistent malarial symptoms.

Case 27.—Mrs. B., aged twenty-eight years; January

20th to February 9th; nineteen days; died. This woman was exhausted by nursing a child ten months old, weighing over twenty pounds, as well as thoroughly poisoned by gases arising from defective plumbing and from living near the Wingohocking Creek, then an open sewer. She commenced with a pulse of 120 and temperature of 103.5° F., the first day I saw her. Bryonia 6, rhus toxicodendron 6 and hyoscyamus 6 were given on three consecutive days, when the pulse was 120 and temperature 102.5° F., morning and evening. The fifth day it reached 104.5° F., when sulphur was given morning and evening, and arsenicum through the day every hour. The pulse continued at 120; the temperature lowered to 103° F. the next day, then to 101.8° F., and did not rise again above 102.5° F. On the ninth day the pulse rose to 136, and on the twelfth to 150, and so continued to the end. The temperature the last week was 101.5° F. and under. Hæmorrhage from the bowels occurred. Sudamina broke out profusely on the seventeenth day. On account of vomiting, rectal alimentation was resorted to. The pulse went up to 180; the respiration to 54, and the temperature was 99.5° F., and the patient died at 4 o'clock the next morning.

Case 28.—Bella U. Y., aged seven and a half years; February 5th to 23d; eighteen days. Temperature, 99° F.; pulse, 120. Nose-bleed, diarrhœa, roseola, were present. It was a mild case. Rhus toxicondendron was the remedy.

Case 29.—Mary C., aged twelve years; February 21st to March 4th, then a relapse from imprudence to March 15; twenty-two days. There were present headache, nose-bleed and diarrhœa. The pulse was 104 to 108, and the highest temperature 103.6° F. Rhus toxicodendron, lycopodium and sulphur were the medicines used.

Case 30.—Florence D., aged twelve years; February 22d to March 24th, afterward a relapse to April 14th; fifty-one days. This case had greater prostration, nervousness, sleeplessness and bone pains than is usual. Pulse, 112; the highest temperature was 104° F. Rhus toxicodendron was the principal remedy. Dr. A. Korndœrfer was in consultation. Psorinum 200 was used as an intercurrent remedy, and cocculus indicus for the sleeplessness.

CASE 31.—John T., aged eleven years; December 12th to 26th; fourteen days. Pulse, 100; temperature, 103.5° F. Bryonia 6, arsenicum and china were used. It was a mild case.

CASE 32.—Lizzie L., aged twenty-four years; single; March 3d to April 3d; thirty-one days. Pulse, 100; temperature, 105° F. Pain in back, muscles and long bones were complained of. Arnica 6 and mercurius vivus 6 were used, and, during the diarrhœa, lycopodium. For nervousness in this case, pulsatilla 6 was given. Occipital pains and sleeplessness were relieved by mercurius vivus 6th.

CASE 33.—James F. P., aged seventeen years; May 1st to June 6th; thirty-seven days. Pulse, 100; temperature, 102.5° F. Bryonia and rhus toxicodendron were the medicines. A moderate, but persistent case.

CASE 34.—Leonard E., aged twenty-three years; teamster; August 3d to September 6th; thirty-three days. Temperature, 103.6° F. Bryonia and rhus toxicodendron were employed.

CASE 35.—Samuel N., forty years; plasterer; August 7th to September 23d, then a relapse (from eating meat) to October 29th; sixty-six days. Pulse, 100; temperature, 103° F., and during the relapse, 103.5° F. Belladonna, bryonia, baptisia and china were the medicines that proved serviceable.

CASE 36.—Stella N., aged eleven years, daughter of Case 35; August 14th to September 23d; forty days; pulse, 160; temperature, 102.5° F. Mild case with repeated moderate nose-bleed. Belladonna, bryonia, arsenicum and lycopodium were useful.

CASE 37.—Earle R., aged thirteen years; August 31st to September 14th; fifteen days. Nose-bleed, diarrhœa and fever were present. It was a mild attack. Bryonia and sulphur were used. No temperature record taken. All my thermometers were with other cases.

CASE 38.—Edwin T., aged nine years; July 28th to August 20th, 1890; twenty-three days; pulse, 100; temperature, 104° F. No diarrhœa occurred. Bryonia, rhus toxicodendron and china were employed to advantage. The patient, who is a very delicate boy, suffers from inactive Pott's disease. He made a good recovery.

CASE 39.—Cora B., aged sixteen years; August 24th to September 6th; thirteen days; pulse, 108; temperature, 104° F.

Bryonia 6th was the only remedy used. This medicine seemed to shorten the attack.

CASE 40.—Albert J. Y., aged forty-eight years; merchant; January 26th to March 5th; thirty-eight days. This case occurred in a worn-out business man. The prostration was very great, the pulse was 88 to 96 and the temperature ran along at 102° F., reaching 102.5° F. as the highest during the first week. At the end of the second week the temperature was below 100° F.; at the end of the third week it was 98° F.; pulse 88 to 96. During the fourth week it rose for one day to 102° F., and a few days later came to normal. The attack set in with inflammation of the kidneys. which continued, with a reduction in its severity to the end. During the fourth week the prostration was so great, and the heart's action so feeble, we did not allow him to rise from his pillow. We fed him every hour. Nausea interfered with alimentation, and we resorted to champagne as a stimulant and small quantities of food at short intervals, no two supplies in succession being of the same kind. The remedies used, one at a time, were bryonia, hyoscyamus, acid phosphoricum, mercurius vivus, rhus toxicodendron, china, arsenicum, sepia and phosphorus. The patient was restored to better health eventually than he had enjoyed for several years.

CASE 41.—Alexander S., aged twenty-three years; coachman; February 16th to March 6th; eighteen days. A case of walking typhoid. I sent him from my office on his second appearance and put him to bed for two weeks. Rhus toxicodendron was the only remedy given. Pulse, 88 to 96. No temperature taken.

CASE 42.—Robert W., aged eighteen years; architect; July 27th to August 14th, then a relapse to September 8th; forty-three days; pulse, 88; temperature, 103.5° F. No diarrhœa characterized this case. Bryonia 6 was given almost throughout the entire attack, although a few doses of rhus toxicodendron at times, as an intercurrent, were administered.

CASE 43.—Katie G., aged eleven years; October 28th to November 15th, 1890; eighteen days; pulse, 120; temperature, 103.2° F. on the third day, 104° F. on the fourth, after which time it gradually diminished and was nearly normal by the tenth day. Bryonia 6th was the only remedy given for the first four days,

then a few doses of rhus toxicodendron 6x and the bryonia resumed, and continued to recovery. Thirteen visits were made this child, but a thermometer was left at the house and the temperature regularly noted morning and evening.

CASE 44.—Miss A. M., aged sixteen years; eighteen days. I attended this case, in consultation with Dr. A. Korndœrfer, from November 13th to December 11th. Pulse, 112; temperature, 103.5° F. and below. Rhus toxicodendron 30 and hyoscyamus were the principal remedies, and they were sometimes given in alternation. The case recovered in eighteen days.

CASE 45.—Miss Lizzie G., aged twenty-five years; fifteen days. Was taken, December 24th, with symptoms resembling peritonitis, but in a few days showed the characteristics of typhoid fever; but the temperature did not rise very high and subsided by January 8, 1891. Bryonia was used, and later, hyoscyamus, with sulphur for the diarrhœa. This young lady lost the middle lobe of the right lung some years ago by an abscess, which was aspirated and washed out by Dr. M. MacFarlan as consulting physician.

CASE 46.—Mr. William S., aged forty-one years; eighty-one days. An active, overworked business man was taken, October 5th, with typho-malarial fever. The pulse and temperature ran along for weeks at near 100, sometimes above, sometimes below, and the highest temperature reached was 103° F. There were complications in the hæmorrhoidal inch, and the fever simply persisted. China seemed to be the proper remedy, and at one time, in the third week, seemed as though it would terminate the fever, and was given in all potencies. The fever returned with slow and persistent vigor at 99° F. and 100° F., and was not broken up for some weeks. The consulting physician recommended quinine, which was given in sufficient doses to cure, but it did not. The remedies were studied over, careful selections made, and the patient recovered by Christmas day.

CASE 47.—Mrs. D., aged twenty-five years; taken ill January 12th; last visit, March 1st; forty-seven days. Her pulse was 124, and highest temperature 104° F. I was taken with la grippe a few days after being called to see her. My colleagues, Dr. N. A. Tomlinson and Dr. A. Korndœrfer, carried her safely through to recovery.

CASE 48.—Miss Esther S., aged fifteen years; ill March 1st to April 6th; thirty-six days. This was one of the most severe cases I ever saw recover. The pulse rose to 120 and the temperature to 104.5° F. on the fourth day, with profuse nose-bleed, diarrhœa, hæmorrhage from the bowels, and delirium. Lycopodium 6th did noble work here, and reduced the temperature to 101.5° F. by the fifth day; and although the temperature did not rise again above that figure, the persistent symptoms of the disease would show in hæmorrhages from the bowels, tympanites, increased respiration, bronchial disturbances, and the apathetic condition of the mind. She recovered, and was walking about her room in thirty-six days. Bryonia and tartar emetic were given after lycopodium had reduced the fever to the line of safety.

CASE 49.—Florence M., aged twelve years; March 15th to April 12th, 1891; twenty-eight days. Pulse 100, temperature 104.5° F., on my second day's visit. Bryonia 6th reduced it to 102.5° F. in three days, when lycopodium and hyoscyamus each had their work to do. A relapse occurred March 22d, when sulphur 6th proved to be the remedy to finish up the case. The patient was of the psoric diathesis.

CASE 50.—Dudley C., aged twelve years; ill from April 5th to May 28th; fifty-three days. A malarial locality and sewer-gas poisoning were no doubt the cause of the attack. Pulse 100 for days together. Temperature rose to 104° F. on the fourth day, then gradually subsided to 102° F., where it remained for two weeks with variations. Bryonia was the remedy until an attack of bronchitis supervened on April 22d, and the temperature rose to 103° F., when pulsatilla 6th overcame that difficulty. On April 30th we moved him to another and healthier location, and by May 8th he was about the room. A cold wave affected him, and he went to bed with a temperature of 102° F. for several days, when bryonia again came to the rescue. He afterwards had œdema of the limbs and feeble action of the heart, but after May 28th was off my list. Arsenicum 6 was the last remedy.

The total number of cases treated was fifty, and the number of deaths one. The highest temperature was 106° F., and the highest pulse 150 and above. The least number of days of attendance

was thirteen, and the greatest number of days of attendance was eighty-one, while the average number of days of attendance was thirty-four and a half. The medical attention commenced with the first visit, and continued until the patient was able to walk out. The number of remedies used was forty-three. Those medicines used in but one case each were: Arnica, amyl nitrite, carbo vegetabilis, chamomilla, Carlsbad water 20x, coffea, cocculus indicus, ignatia, kali carbonica, nitric acid, natrum sulphuricum, nux vomica, psorinum, rumex, quinine, sepia, stramonium, spongia, strophanthus, veratrum album, and tartar emetic. Those used in two cases each were: Aconite, antimonium crudum, cimicifuga, natrum muriatum, opium, phosphorus, veratrum viride. Those used in three cases: Belladonna, mercurius vivus, acid phosphoricum. Those used in greater frequency were as follows: Arsenicum, in twelve cases; bryonia, in twenty-six cases; baptisia, in seven cases; china and hyoscyamus, in eleven cases each; pulsatilla and lachesis, in four cases each; lycopodium, in fourteen cases; rhus toxicodendron, in twenty-three cases; and sulphur, in ten cases.

The following is the order of remedies used in greatest frequency: Bryonia, rhus toxicodendron, lycopodium, arsenicum, china officinalis, hyoscyamus, sulphur, baptisia tinctora, lachesis, and pulsatilla.

I think I can truly say that in a majority of typhoid cases we can get them under control by the selection of the properly-indicated Homœopathic remedy within a week or ten days, and the fever will not rise again above 103° F. except from some imprudence in food, exposure, or getting about too soon.. The Homœopathic remedy will reduce the temperature more effectually than anything else I know of.

The disinfectants used were the peroxide of hydrogen, Platt's and Poley's chlorides. For washing the hands, the usual chloride of mercury and tartaric acid tablets were used.

Dr. Cumberland, Pasteur's assistant, and Drs. Monier and Cadiac made experiments which prove that essence of *cinnamon*, when sprinkled in the room of a typhoid fever patient, kills the bacteria within twelve hours, and prevents the disease from spreading.

Analysis of Temperatures.

Temperature.	Patients.
106°,	1
105°,	4
104.5°,	7
104°,	15
103.5°,	7
103°,	2
102.5°,	6
102°,	2
101.5°,	1
99°,	1
Not taken,	4
Total number of cases,	50

Case 27, the only fatal one; highest temperature, 104.5°; ill nineteen days.

REPORT OF THE BUREAU OF SURGERY.

The Field and Limitations of Cerebral Surgery, by Clarence Bartlett, M.D.
Notes on Dry Dressings, by J. H. McClelland, M.D.
Potentized Medicines in Surgical Cases, by Malcolm Macfarlan, M.D.
Supra-Pubic Cystotomy for Encysted Vesical Calculus, by Carl V. Vischer, M.D.
Notes on Intestinal Surgery, by W. B. VanLennep, M.D.
Synovitis, by L. W. Thompson, M.D.
Notes on the New City Hospital, Hamburg, Germany, by J. H. McClelland, M.D.

In the absence of the Chairman, Dr. J. William Giles, Dr. C. P. Seip was unanimously requested to take charge of the Bureau.

THE FIELD AND LIMITATIONS OF CEREBRAL SURGERY.

CLARENCE BARTLETT, M.D., PHILADELPHIA.

All great advances in medical science have exhibited three stages in their careers. When first announced they are received with enthusiasm on every side, this enthusiasm leading to their application to cases in which they are not at all appropriate; next comes a period, the direct outcome of the first, the result of the misspent enthusiasm, in which they are treated with unmerited disfavor; and, lastly, appears the time when sober counsels prevail, and the subject is reviewed and studied with wise conservatism. Cerebral surgery has outlived the first two of these periods, and is now a subject for calm consideration. It is the purpose of the present paper to review as concisely as possible what seems, to the author, to be its proper scope in the treatment of diseases of the brain.

The necessity for operative treatment of the majority of cases

of fracture of the skull is now pretty generally recognized. In cases of compound depressed fracture there seems to be no differences of opinion as to the proper course to be pursued. The same is true of simple fractures when attended by evidence of cerebral disturbance. But in the case of simple depressed fractures without marked symptoms, authorities are at variance. The opinion is, however, growing that even these cases should be operated. This radical procedure has strong reasons for its endorsement, as is shown by the fact that over fifty per cent. of the cases of fracture of the skull in early life are followed by epileptiform convulsions; and not only this, but some of them develop mental defects, as loss of memory and general mental deterioration. In view of this, and especially when it is as well recognized as it is at the present time, that secondary operations for the cure of traumatic epilepsy are only successful in a very small percentage of the cases, it seems to me that the views of those who recommend operation in every case of depressed fracture are entitled to the greatest respect. Whenever there exists a doubt as to the proper course to be pursued, I think that that doubt should be decided in favor of the more active measure and operation performed. The additional risk to the patient is very small, as modern surgery has made trephining a comparatively safe operation.

In cases of injury with laceration of the brain structure, every care must be taken to prevent the formation of cicatricial tissue within the structure of that organ. Such tissue, it is well known, is very apt to be a cause of epilepsy. Even the adhesions between the membranes following an ordinary trephining have produced epilepsy. Ragged pieces of brain must, therefore, be trimmed off, of course, using proper judgment. Objection to this procedure has been made because of the danger of thereby damaging cerebral functions. This danger is more apparent than real, for where portions of the cerebral cortex have been excised for therapeutic purposes, the loss of the corresponding function has been but temporary.

Intracranial hæmorrhage is an accident, for the benefit of which much has been expected from surgery. Unfortunately, however, in the majority of cases of apoplectic extravasations, the lesion is situated so far within the brain substance, and, moreover, within

the immediate vicinity of such vital parts, that direct surgical treatment is well-nigh hopeless. Any operation must do more damage than the original disease. Horseley has proposed the ligation of the common carotid artery with a view of stopping the hæmorrhage. Inasmuch as the ordinary measures in use in these cases can do but little good, this heroic procedure is worthy of consideration.

If cerebral surgery is a doubtful expedient for intra-cerebral hæmorrhage, it is not so when the effused blood is sub- or extra-dural. In all cases of hæmorrhage from the meningeal vessels, trephining should be performed as soon as the nature of the lesion is recognized. The majority of cases of meningeal hæmorrhage result from injury. The one symptom that of all others points almost unerringly to the existence of the hæmorrhage is an interval (however slight) of unimpaired functions between the time of reception of the injury and the onset of symptoms. Usually we have as a guide to the seat of operation evidence of external injury. Sometimes we are not so fortunate, and must then rely upon our knowledge of cerebral localization. In some rare instances the external injury is at one portion of the head, while the intra-cranial lesion is at a far distant point. The latter condition probably prevailed in the case of a boy seen by me with Dr. E. H. Kase about one year ago. While at play in school he was accidentally knocked down and injured by a playmate. Nothing was thought of it at the time; but within a few hours he began to feel badly, and then there appeared unilateral convulsions. The only evidence of injury to the scalp was in the left temporal region. Notwithstanding that the convulsions were left-sided, I advised trephining (which was performed by Dr. W. B. Van-Lennep) at the seat of injury. The patient was nearly moribund at the time. Throughout the operation had to be interrupted for the performance of artificial respiration. Nothing was discovered after the removal of the button of bone. His condition was such that it was not deemed advisable to operate on the right motor area. He died within a few minutes after the completion of the operation. No autopsy was permitted. I regret greatly that I did not advocate operation at the seat suggested by the symptoms. In a case seen this day, also a patient of Dr. Kase, the initial

symptoms were strongly suggestive of delirium tremens. The history of the case and the absence of any evidence of injury precluded any other diagnosis. But ere long the patient became convulsed on the left side of the body; and these convulsions after lasting several hours were succeeded by a complete hemiplegia. The man had been "off on a big drunk" and had returned home in a fairly sober condition. While at the table his first furor appeared. The patient was removed to the Hahnemann Hospital, where, in consultation with Drs. Thomas and James, it was decided that immediate operation was necessary. Dr. James, therefore, trephined over the middle of the fissure of Rolando, and removed about three ounces of clotted blood. The seat of operation was here selected because of the localizing symptoms.

Even when the extravasation is not sufficient to cause death, operation is wise as a preventive of permanent impairment of cerebral functions, for where so much of the cortex is affected, as there must be in meningeal hæmorrhage, perfect restoration to health cannot be expected under conservative treatment.

The removal of the effusion in cases of chronic hydrocephalus is an old procedure. It is one of very doubtful utility. Keen has lately proposed that the ventricles be drained in these cases. In one or two instances much benefit has been obtained from tapping the ventricles, but that relief was evanescent, the patient finally succumbing to the inevitable. The hope has been fostered that as laparotomy has cured tubercular peritonitis, opening of the cranial cavity may cure tubercular meningitis, a hope that has not thus far been realized, despite several operative attempts to do so. In acute ventricular effusion, tapping has been but seldom performed. I can recall but one case, reported by Mayo Robson, and in that one recovery ensued.

Tapping and washing out the ventricles is a rational measure in case of hæmorrhage or rupture of abscess into these cavities. It is an almost hopeless one, however; in fact, in every case it has been resorted to nothing was accomplished.

Within the past year Lannelogue, of Paris, has proposed an operation for the relief of idiocy dependent upon microcephalus. His idea is that some cases of deficient cerebral development in children result from premature closure of the sutures of the skull.

To remedy this he proposes that artificial sutures be made to liberate the necessarily compressed brain. This operation, which he calls craniectomy (and Keen, linear craniotomy), he has performed in twenty-five cases with varying degrees of success. In no case can I see that remarkable results have been secured, though improvement resulted in nearly all. My experience with the operative treatment of microcephalus has been limited to two cases, both operated by Dr. W. B. Van Lennep, the first one a child of three years, who died three days after operation; and the second a boy of five years who has been slightly improved. In these cases favorable results cannot be looked for until a long time after operation, and not even then unless the treatment is supplemented by proper education. Some cases of idiocy undoubtedly are secondary to premature closure of the cranial sutures. In these craniectomy is an authorized though a doubtful procedure. Where there is a primary lack of cerebral development, the microcephalus and closure of the sutures being secondary, absolutely nothing can be accomplished by surgery.

The propriety of operating in cases of idiocy is a question which each one must answer for himself. Certainly there exists no more pitiable objects than just this class of cases. It has been said that "a poor remedy is better than no remedy." If the operation is performed and relieves, it is a good thing; if the patient dies, the friends say that it is better off; and if nothing is accomplished, no harm is done.

A less dangerous operation than craniectomy is simple trephining. According to Keen, this has in some cases accomplished as much as the more formidable procedure.

General paralysis of the insane is an ailment that has hitherto resisted all our best directed efforts. In two instances patients suffering from it have been trephined, and a great though but temporary benefit obtained. The remarkable variations in symptoms of paretics makes it doubtful whether this improvement was a *post hoc* or a *propter hoc*.

Concerning the treatment of cerebral abscess, I think there can be but one view. This disease is inevitably fatal. As soon as one is sure of his diagnosis, just that soon must he insist upon operation. The difficulty is to be found in being sure of the diag-

nosis, for strange coincidences may occur, leading to singular clinical pictures. This was well illustrated in a case coming under my treatment last December. The patient was a tall and rapidly growing girl of twenty years. She had several years been suffering from fœtid aural discharge which I had tried in vain to cure, partly because of the nature of the case, and partly because of her lack of perseverance in treatment. Suddenly she developed intense headaches; within twelve hours she was delirous, and in twelve more, unconscious. She presented every evidence of meningitis. Knowing her history I felt tolerably certain that her chronic otitis was the cause of her sickness, though the possibility of a cerebro-spinal meningitis was entertained. On the third day there developed a petechial eruption on the extensor aspects of all the large and medium sized joints and a suppurative keratitis appeared. After a long but tedious illness she recovered, though the sight of one eye was destroyed. Hers was a case of sporadic cerebro-spinal meningitis.

The necessity for care was still further exemplified in a case seen with Drs. Vischer and Shallcross. The patient, a man of twenty-five years, had had an offensive aural discharge for a long time. Suddenly he began to suffer from severe headache, fever, and finally facial paralysis on the side corresponding to the diseased ear. The knee-jerk on that side was very much exaggerated. I felt that there was certainly some brain involvement, and advised that the propriety of operation be entertained. Pending this he was removed to a private ward in the Hahnemann Hospital. Here under proper hygienic surroundings improvement began at once. Within twenty-four hours the left knee-jerk was perfectly normal; the headaches ceased; and the facial paralysis began to improve. There was undoubtedly a beginning of an extension of inflammation from the ear to the brain structures; but proper treatment "nipped this in the bud."

So I say one must be sure of his abscess before he begins his search for it.

The results obtained from the surgical treatment of cerebral abscesses have been at times brilliant. Though recoveries have followed after operations performed upon almost moribund patients, it is better I believe not to wait until the patient is in such

a low condition. Just as soon as the diagnosis has been established to a certainty, just that soon should the surgeon be called upon.

Certain cases of brain tumor offer inviting opportunities for operation. The average duration of life in patients suffering from this ailment is two years. It is an invariably fatal disease. Tumors involving the dura mater are always capable of being successfully operated. The difficulty that stands in the way of a successful result is the delay occasioned by the many and persistent attempts at a cure by internal medication. Ofttimes medicines work an apparently wonderful but deceptive change for the better. Three times have I seen cases of sarcoma of the dura mater improve so as to lead me to expect a cure; and yet they all eventually succumbed to the disease. In the absence of any reliable cure of brain tumor (aside from syphilomata) by internal medication, one is not justified in waiting long for results if the symptoms are such as to enable him to locate the lesion accurately. But little can be hoped for in operations for the removal of tubercular tumors owing to the tendency to multiplicity of lesions. In the case of a colored boy, treated at the Children's Homœopathic Hospital several years ago, the first convulsions led to the localization of a lesion on one side of the brain; the second convulsion pointed to the other side. No operation was performed. The patient died; and at the autopsy, performed by Dr. Joseph Rodes, now of San Diego, Cal., three tumors were found, one in each motor area, and a third in the occipital lobe.

Infiltrating tumors, like gliomata, offer but little opportunity for successful surgical treatment.

Benign growths are always proper subjects for cerebral surgery.

The surgical treatment of epilepsy offers a big subject for discussion. The ailment is an obstinate one to all measures hitherto proposed for its relief. Cases of the Jacksonian type have been, and are still being, treated by excision of the centre in which the discharge begins, and with apparent success. The permanence of these cures is still an open question, for almost all the cases have been reported too soon after operation to enable us to decide positively on this point. Almost any operation on an epileptic will

lessen the number of his seizures temporarily. Even accidental traumatisms, as a fractured bone, or a severe burn, will accomplish an equally good result. Thus far the weight of evidence is hardly in favor of the value of excision of the appropriate cortical centre in Jacksonian epilepsy.

The commonly accepted view of the treatment of traumatic epilepsy is that operation nearly always cures. The actual state of the case is that operation rarely effects a radical cure, though improving the patient's condition in nearly every case. Yet one should not deny the many the little chance for cure to be obtained from an operation that offers but comparatively little risk.

Cicatrices of the scalp may be a point of irritation, and should be removed.

Aside from the general complaints enumerated above, the propriety of the surgical treatment which we must recognize under certain indications, there are anomalous cases which have been apparently benefited by trephining; why we do not know, unless it be because of the relief of intracranial tension.

DISCUSSION.

Dr. Sanders said that the paper reminded him of a case which came under his observation, that of a letter-carrier, who had frequently had trouble with the left ear. Finally, he took a violent cold, which resulted in a severe headache, with extreme pain and rigors, followed by high fever. There was every indication of the formation of pus. The trouble was located in the mastoid bone, and was referred for treatment to Dr. W. A. Phillips, Professor of Otology in the Cleveland Homœopathic Hospital College. The bone was trephined, and two tablespoonfuls of laudable pus liberated. The patient made good recovery. He thought that many cases of local abscess of this character are the result of a violent otitis media, which is neglected through timidity on the part of the attending physician.

DRY DRESSINGS.

J. H. McCLELLAND, M.D., PITTSBURGH.

For several years past I have been dispensing more and more with wet dressings. That the keeping of wounds sopping wet is the cause of many failures to secure immediate union, I am convinced; *first*, because of the devitalizing effect of the continued moisture, and, *second*, because with water dressings, or calendula, or, worse than all, poultices, we simply foster and invite the germination of microscopic intruders. Parenthetically let me remark that the true field of a poultice as an emollient is before an abscess is opened. Immediately the opening is made, an antiseptic gauze is the correct dressing to be used. The poultice is vile and worse than useless.

In a conversation with my friend, Prof. Helmuth, recently, I remarked that if we could do up a cervix for a few days after an operation in a perfectly dry dressing, we would oftener secure perfect results as a consequence, for I had adopted the dry dressing of wounds in general.

"Why," he replied, "Von Bergmann, of Berlin, has just written a paper on the dry dressing of wounds in a recent journal." So my thunder was gone. However, as many of my colleagues, like myself, may not have read this paper, this brief note may still serve to call attention to a surgical method of value.

Briefly stated, the point is: Whenever a wound, from accident or design, can, in the nature of it, be done up dry, by all means do it up dry.

Beginning with a few layers of antiseptic gauze, we next wrap the part in absorbent cotton, thus completing a *perfectly* dry dressing. When there is some laceration, the surface may be powdered over with boric acid, aristol, or iodoform; then the dry dressings as above.

It will be found, too, that in burns or scalds of the first degree we may often prevent the separation of the epidermis, which makes very slow work, by putting on a perfectly dry covering over the injured surface.

In superficial wounds, say of the face, only a sufficient number of adhesive strips or sutures should be used to secure coaptation,

and the line of the wound allowed to dry. No other dressing (except in a very young child for protection, then a strip of gauze) should be employed. There will be less likelihood of suppuration and the scar will be much smaller. This, we know, is a matter of no small importance in face wounds.

I by no means throw overboard our old friend, calendula. The sphere of this drug, or any other, is in morbid conditions. If a wound is healthy and granulation proceeding in a normal manner, our whole duty is done when we keep hurtful things out of it and permit nature to finish its perfect work. On the other hand, if a wound is in an unwholesome condition, and the healing process retarded or perverted, then remedies such as calendula, as of old will surely be of service.

My only excuse for this brief note (written, by the way, on shipboard), is that I may not entirely fail to respond to the call of the Chairman of the Bureau of Surgery.

DISCUSSION.

Dr. H. W. Fulton reported a case of a gun-shot wound in the palm of the hand, the missile being forced through. He dressed it with iodoform, packing the wound thoroughly with antiseptic gauze. The next day patient reported the wound in good condition. On the second day after, the doctor removed the dressing and found the wound perfectly dry, He packed it again and let it alone for four days, when, noticing a slight odor from the wound, he removed the dressing, cleaned the part carefully, and re-packed as before. The part healed perfectly without further trouble.

President Korndœrfer spoke of the case of a boy who, while playing with a slab of marble, allowed it to fall suddenly, with the result of mashing his thumb very badly. The doctor washed the wound very carefully and dressed it dry with salicylated rubber plaster, making a complete casing over the thumb. Two days after, he saw the patient, found the condition improving, and continued the dressing. On the seventh day, as there was a slight discharge, he removed the dressing and found the thumb almost healed. He washed it carefully and re-applied the plaster with the best of results. The thumb, which at first sight seemed to demand amputation, was saved by the dry dressing.

POTENTIZED MEDICINES IN SURGICAL CASES.

MALCOLM MACFARLAN, M.D., PHILADELPHIA.

OPERATIVE procedures seem to have reached a state of great perfection, because improved methods, being mostly mechanical, are at once self-evident, need no argument, and require only trial. The skill and genius of the masters of surgery, joined with that of the mechanic, have devised instruments which seem to have almost reached the limit of faultlessness.

Methods, as such, appear to have become complete. Of late years, new books and magazines have, in their instrumental descriptions, been simply repetitions, with unimportant differences. Everything was ready for the evolution of an entirely new principle in surgery. The antiseptic treatment, which evidently is the beginning of a new era in the practice of medicine as well, throwing great light on both the cause and rational treatment of disease. Its forms of application are continually changing, and will keep on doing so, until experience settles disputed or uncertain methods, and points to better. The new departure deals with the destruction and prevention of manifest or probable disease-germs, and is almost exclusively external and physical in its curative action, assuring results in minor cases and allowing of successes in operations of magnitude, which could not be hoped for without its aid. If fair trial proves this, its adoption by the man intent only on healing the sick follows.

It seems reasonable that if a single remedy such as corrosive sublimate, so diluted with water, can work such wonders externally, that it may, under proper conditions, or diluted sufficiently to harmonize with the delicate tissues, do as wonderful work internally. Advocates for antiseptics are, of necessity, running towards Homœopathy, approaching and acknowledging its truths by an entirely different direction from that of the Homœopath.

The preparation and dilution of tablets and cultures are strikingly like its methods. The enormous amount of milk sugar tablets and triturates, parvules and mother tinctures, now being sold and everywhere used by the prevailing school, especially in

the country districts, shows that current Homœopathy is being rapidly absorbed, and that the difference in practice exists mostly in name.

The use of antiseptic and hypodermic tablets have partly led to the employment of these more convenient and Homœopathic forms of medicine for internal use. The choice of more and more dilute preparations led Hahnemann, by induction, to the discovery of dynamization, which was the orderly sequence of his precious labors. It is to add testimony to the value of that form of medication, as furnishing a protection against infection and contagion, that this paper is written. Every one of experience in the practice of medicine knows that there are some who are wonderfully exempt from certain infectious diseases, although much exposed. The exact reverse is also true—and that later on the conditions mentioned in either case may cease to exist. The cause is found in conditions peculiar to the individual. It has been proven over and over again, especially by the early Homœopaths, that dynamized medicines do control these conditions of resistance, as instanced by the protective power of rhus toxicodendron in erysipelas and many other examples, and acting similar to vaccination against small-pox, or even where affected the power of the septic influence is broken by the remedy.

The statements of Hahnemann and his followers are not convincing to the investigator, unless proofs over and over again are furnished to his senses. When this is done he is fixed; nothing can shake him. Whereas, if he is trading on other people's views, he is tossed about like a ship at sea, without map or rudder. The whole matter, after all, is one of personal experience, concurrent testimony, and credibility of the observer. The dynamized medicine will manifest its favorable action under the most adverse circumstances, but should have all the benefit of good nursing, healthful and proper surroundings, antiseptic and local helps.

Its employment gives the Homœopath an additional and extraordinary advantage, relieving constitutional states such as sweats, exhaustion, diarrhœa, hectic and vomiting, when local and crude means would be of no use. The simple and general rule given by the founder of the system in the choice of the medicine in medical cases holds good in surgical—the agreement of the to-

tality of the symptoms and spirit of the remedy with the disease or condition. One may find in aconite, belladonna, rhus toxicodendron, arsenicum, bromine, creosote, turpentine, sulphite of lime, opium, ergot, the preparations of mercury and zinc, the remedies for usual surgical diseases.

To specify particulars would be to write out a proving and fill a small volume. Reference to a concise, reliable materia medica, or a person of experience, will guide the investigator.

SUPRA-PUBIC CYSTOTOMY FOR ENCYSTED VESICAL CALCULUS.

CARL V. VISCHER, M.D., PHILADELPHIA.

THE object in presenting this report is two-fold. First, to point out the importance of making a careful physical examination, even in those cases where the subjective symptoms seem trivial, and secondly, to briefly consider a subject which, judging from the current literature, is not of frequent occurrence.

Mr. W. S., aged thirty-five, had always enjoyed good health until some twelve years ago, since which time he had been suffering, on and off, from dysuria, which frequently became greatly aggravated, the pains shooting from the rectum through the perinæum to the glans penis; ordinarily, however, he experienced but comparatively little pain, save at the end of micturition, at which time it became quite acute, especially in the glans. His principal trouble, however, that which annoyed him most and for which he sought relief, was his urine. This was exceedingly cloudy, on standing depositing large quantities of mucus, and was of an extremely strong odor. On questioning, it was learned that on one or two occasions he passed some blood with his urine; in other respects his history was negative. An examination of the urine showed it to contain a large amount of pus, great numbers of triple phosphates, bladder-cells, and some albumin—the latter, however, could be accounted for by the former; there were no kidney elements found. The history certainly spoke for prostatic

trouble, and the urinalysis for the presence of a cystitis, for which he had been treated more or less constantly with but temporary relief. As neither of these conditions are likely to be idiopathic, and the most frequent cause of them being denied, without a careful physical examination one would certainly have been at a loss to account for the symptoms. This being done, however, the cause was readily explained. A finger introduced into the rectum found the prostate normal; about a finger's breadth above this, and to the right, a tumor was detected on the posterior wall of the bladder, extending beyond the reach of the finger, of almost a stony hardness. The bladder having been filled with some eight ounces of Thiersch's solution, a Thompson's sound was introduced, revealing slight trabeculation; otherwise nothing could be detected until the water was allowed to flow out, at the same time making the usual manipulations with the searcher; as the bladder emptied itself and became contracted, a tumor, corresponding to the one detected by the rectal examination, was found, the surface of which was perfectly smooth and very hard, but giving no click. A tumor of such a character being almost unheard of in the bladder, a sacculated stone was suspected, and on introducing a finger into the rectum with the sound in the bladder, the presence of a calculus could be quite readily made out, by making alternate pressure with the finger and sound. The stone, being some little smaller than the cyst in which it lay, it could be moved from one side to the other. Feeling confident of the diagnosis, supra-pubic cystotomy was advised; the other methods for the removal of stone were excluded for obvious reasons. After due consideration on the part of patient and friends, operation was consented to; and accordingly, with the kind assistance of my friend, Dr. Congosto, the bladder was opened in the usual way, excepting that a finger introduced into the rectum took the place of Peterson's bag.

The patient having been placed in Trendelenburg's position, viz., elevated pelvis, on opening the bladder the tumor was pushed upward and forward, when the tissue covering the stone, which apparently was inflammatory in origin, was incised, and after some difficulty the stone, which was of no mean size, and composed of uric acid nucleus with a phosphatic covering, was delivered—the difficulty arising in that the calculus was firmly im-

bedded in its long axis. After thorough irrigation, a Dittel modification of Trendelenburg's drain was introduced, and the abdominal walls partially united by the introduction of two stitches. The wound was dressed with iodoform gauze. The patient made a rapid recovery, the highest temperature being $100\frac{2}{5}°$ F. on the day following the operation.

The literature on the subject seems very meagre. In the operated cases reported, the stones were either in diverticulæ or not completely encysted. Fenwick mentions one in which a large calculus was partially encysted, and so adherent to the mucous membrane that it was necessary to remove it by means of a mallet and chisel. Other instances of encysted or rather sacculated stone are reported where the calculi were of small size and several in number. One or two cases of completely encysted stone reported were only found post-mortem. Pathologically, but little is known, save that diverticulæ are comparatively rarely found congenital when they not infrequently, for obvious reasons, are the direct cause of stone formation. The sacculations in which calculi are more often found are secondary to the development of the stone, the weight of which forces the mucous and sub-mucous coats of the bladder between the muscular fasiculæ, in that respect differing from the true or congenital diverticulæ, as they are made up of the layers of the bladder. In the case just cited, there apparently was a congenital diverticulum, or an exaggerated cœcal or retro-prostatic pouch, which, owing to the irritation of the stone, gave rise to a plastic inflammation, which resulted in the complete encysting of the calculus.

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DISCUSSION.

Dr. L. W. Thompson related a case seen by Dr. John E. James and himself, in which all the symptoms of calculus presented, though the presence of the stone could not be determined by the use of the sound. On operating, several encysted calculi were found just anterior to the prostate gland. Another case was of calculus in the female, for which Dr. James operated, making a vaginal cystotomy. Here, too, it was impossible to detect the presence of the stone with the sound. A peculiar case which occurred in his practice was that of a boy who presented all the symptoms of a stone. It afterward developed that these symptoms, together with the grating sound, were caused by the presence of a piece of wire in the urethra. The wire being removed, all symptoms were relieved.

Dr. Korndœrfer related a case in which the indications were for the presence of a calculus, but the stone could not be detected by the sound.

NOTES ON INTESTINAL SURGERY.

WILLIAM B. VAN LENNEP, A.M., M.D., PHILADELPHIA.

I had the honor, at the Pittsburgh meeting two years ago, to present a *résumé* of some experimental intestinal work, and, as a result, suggested a modification in the technique of circular enterorrhaphy. In support of this I showed specimens taken from a number of dogs, and reported a successful clinical case. By a rare piece of good fortune I have, within a few days, been enabled to make the history of this first-recorded operation by this method complete. It seems but right, then, that this report should be presented to the Society, the members of which so kindly listened to the incomplete history of the case, as well as the experiments that led up to the technique employed.

As stated in my former paper, the patient was operated for strangulated hernia, twelve inches of gangrenous intestine resected,

and the ends united with rings or splints of rubber drainage-tubing in a manner that will be referred to more fully further on.

It was also stated that she made a good recovery, the openiug being treated after the method of McBurney.

While her general health and, particularly, the bowel functions, were excellent, the hernia relapsed within a year, working downward and inward alongside the vulva until it attained a considerable size. For a time a truss retained it, but soon this was insufficient. With the protrusion came dragging pain in the abdomen, which finally incapacitated her for her household duties. This was so severe that I was inclined to attribute it to traction on adhesions. To these symptoms were added recurring warnings of impending strangulation, so that, finally, both she and her husband insisted on relief by operation. This was the ordinary one for radical cure, and was done, as before, at the Hahnemann Hospital,—splitting the sac up to the abdominal opening; detachment and amputation of the former; accurate suture of the peritonæum to insure a smooth surface without a dimple (when the opening is small the neck of the sac is tied); buried suture, without drainage, of all the overlying structures, layer by layer; antiseptic dressing.

I have now practiced this method (Czerny-Riesel) a number of times without any mortality and with as good ultimate results as with any other. The smooth peritonæum, and the restoration of structures to their former relation as much as possible, seems preferable to a large scar, however hard it may be at first. As time elapses it softens and, in contracting, draws down a dimple in the peritonæum to which it is attached. Such a dimple, of course, guarantees recurrence.

In the sac was found adherent large bowel, which was replaced, and the finger introduced with the expectation of finding the rejected gut attached near the opening. There were no adhesions at all. Several loops of small intestine were successively drawn out in the vain hope of *happening* on the desired spot, when the patient obligingly commenced to gag, and the first loop that rolled out was the one we were after.

The line of union was marked by the slightest furrow, across which stretched several thin, soft bridges of connective tissue.

The mesentery scarcely showed any scar, making it almost impossible to find the line of suture. There was but one single adhesion to the mesentery of the gut, about a foot away. This produced such a gradual flexion that no obstruction could result. It was divided, and the oozing stopped by a stitch. The size of the intestine when spread out was exactly the same above, below, and at the line of union. It remained but to prove that there was no encroachment on the calibre inside. Here fortune came again to the rescue. There was a round worm, eight to ten inches long, above the line of union, and it gradually worked into this point. I was then able to roll the intestinal wall between the worm, like a finger inside, and my finger outside. This demonstrated beyond a doubt that there was no thickening in the wall.

Such a complete history gives food for thought, and enables us to draw some useful conclusions.*

It has been stated that the peritonæum of the dog is much more tolerant than that of the human being. In my experiments I invariably found adhesions, except where omental grafts were used. The treatment and care were the same, and yet here was but one single weak adhesion near the mesenteric junction. No omental graft was applied either. The line of union was perfect, and with a minimum amount of inflammatory action, as shown in the presence of the bridges of scar-tissue across the slight groove.

Stricture has been one of the arguments used against circular enterorrhaphy, and the specimens I presented, taken from dogs killed from a few days to several weeks after operation, showed a perceptible encroachment on the calibre of the gut. Either there was no stricture in this case, or it subsequently disappeared. The latter is, of course, hardly possible. It is worth while to remember that a stricture must occlude over one-half the lumen before producing obstructive symptoms, and that a constriction that might be dangerous in the gut of a dog would do no harm in the more capacious human intestine.

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* To this case should be added another successful one. A. Demosten, of Bucharest, in a brochure recently received, reports a case of peritoneal tuberculosis, in which he successfully resected ten centimetres of damaged gut, and united the ends according to this method.

In trying to avoid stricture one is apt to weaken the line of union by apposing too little surface. These two dangers can be avoided by strict attention to some of the details of the technique, which, I think, will bear repetition. After resection, the pouting mucous membrane is trimmed down. The peritonæum and muscular coat can then be turned in to an extent corresponding to the thickness of the mucosa and submucosa before the stricture can begin. The four catgut strands attached to each ring are then passed through the entire wall very close to the free edge of the mucous membrane. There is no danger of these sutures cutting through the firm fibrous submucosa. This is an important structure in any intestinal suture, and, once recognized, can never be forgotten. It is the foundation for stitches applied from within or without. The weak spot, the mesenteric junction, is next fortified by drawing the two edges together with a few interrupted sutures of silk on the inside, and catgut on the outside. The corresponding catgut strands from the rings are then tied, and the tendency to eversion between them overcome by a few (three or four) interrupted stitches of silk. The bridges of connective tissues spoken of corresponded with the location of the silk sutures which no doubt had become encapsulated. No trace of the silk could be felt. A rapidly-applied continuous stitch brings the peritonæum evenly together over all, and is carried down the divided mesentery. Finally, the patency of the gut and the completeness of the union are tested by pressing together the walls below with the fingers, and forcing the intestinal contents into the united portion from above. A leak will be readily demonstrated and closed. In a case reported by me last year, death was due to secondary obstruction, the cause of which was below the united point. Great pressure was necessarily brought to bear on the rings and the line of union, but there was no leakage.*

The rings have several advantages: 1. They keep the lumen open and prevent dangerous overstretching. 2. They hold the edges together with an elastic pressure which will not produce sloughing. 3. They do away with the necessity of 60, 70 or 80

* *Hahnemannian Monthly*, October, 1890.

laboriously-applied stitches. 4. They enable us to use a continuous suture over all, which, without their support, would constrict the intestines like a purse string. 5. The catgut strands swell up and prevent leakage, and in this respect have a decided advantage over silk.

While many American surgeons advocate lateral anastomosis after resection, surgical opinion in Europe and even in this country leans towards the ideal end-to-end union. This is evident from the frequently reported cases of circular enterorrhaphy, and is expressed by Gerster in the last edition of his work on *Aseptic and Antiseptic Surgery*, page 162. After speaking of Senn's and Abbe's work and suggestions, he says:*

"The development of the new operation was brought to its logical culmination by a Homœopathic practitioner of Philadelphia, who, after excising twelve inches of intestines for gangrene, successfully united the gut, end to end, by means of rings made of ordinary rubber drainage-tubing."

Lateral anastomosis undoubtedly has a field where it is desired to exclude certain areas ("physiological exclusion") or unite portions of the intestine of unequal size, *e.g.*, gastro-enterostomy, ileo-colostomy, etc. After resection, however, I have noticed and reported, besides the adhesions, a tendency to distortion or twisting, apparently dependent on the tortuous current. In addition to this there were accumulations in the blind cul-de-sac. The great advantage claimed for this method is that it opposes extensive serous surfaces and favors firmer union. This is aided by scarification. In this connection I was much impressed by an article read at the last Congress of Surgeons, in Berlin, by Kummer.†

The method he proposes, and successfully practiced on dogs and the human cadaver, is the following: After transverse section, the white line, the submucosa, is readily recognized. This is intimately united to the mucous membrane, but can be easily separated from the muscular coat. Seizing the mucosa and submucosa

* It is not necessary to quote the "trimmings" with which the author sees fit or feels compelled to apologize for his honesty.

† *Beilage zum Centralblatt für Chirurgie*, No. 26, 1891, and "Gleaning" in *Hahnemannian Monthly*, August, 1891.

with forceps, the muscularis and serosa are pushed off and turned back like a cuff with the finger nail to the extent of a little more than half an inch. The hæmorrhage is trifling. The mucous cylinders are now resected close to the base of the reflected cuffs, and united by sutures. These cuffs are then turned back and considerable serous surfaces united. The projection is outward, and not into the intestinal lumen, as in the ordinary Lembert suture. Again, the weak point in end-to-end union, the mesenteric attachment, is well protected because, owing to the abundant flap, ample serous surfaces can be accurately approximated. Furthermore, in the Lembert suture there is always danger that a stitch may perforate the mucosa and give rise to fatal leakage. With this method such an accident is impossible. In one experiment the mucous membrane was not united, and the autopsy showed a fæcal abscess between this and the muscularis, although no symptoms had been caused by it before the dog was killed. That the musculo-peritoneal flaps are well nourished was proven by the fact that no gangrene was observed, and that after injecting a colored solution into the circulation, it was found as freely distributed through the flaps as through the rest of the intestine. The specimens showed neither any vestige of stricture nor any distension of the gut above the point of union.

I have recently made some experiments with a view of testing this method. Its advantages are the very slight stricture as compared with ordinary circular enterorrhaphy and the extent of serous surfaces that can be brought into contact. This is particularly useful at the mesenteric junction. It has the drawback, however, of the slow interrupted suture, two layers of which must be carefully applied, as in the ordinary operation. In consequence of this, I have practiced it with the following modification: after preparing the cuffs and amputating the mucous cylinders, the rubber rings are introduced, and the edges of the mucosa and submucosa are drawn together. The union is completed by a continuous suture of catgut. The cuffs are then turned back, and the serous surfaces drawn together with another similar suture of the same material or of fine silk. Here, too, the rings permit the use of the running stitch, and have, in fact, all the advantages already spoken of.

The disadvantages of the operation are the additional time consumed, even with this modification, and the danger that the flaps will slough. The latter complication is to be guarded against by care in peeling off the cuffs. Practice can alone make perfect in this manipulation. Sloughing may be produced, too, if the outside sutures are applied too deeply and too tightly. I have met with these accidents in two experiments. Although Kummer has demonstrated by injection that there is an ample blood supply in a half-inch or longer flap, it seems safer to turn back less. Superficial scarification will hasten and make the union firmer.

Clinical experience can alone decide the place of this new method. If it is shown that the double support of two rows of sutures and the abundance of serous surface add to the safety of the operation, the extra time is a minor consideration when cut down by the use of the rings and the continuous suture.

In conclusion, I would urge upon my surgical colleagues the importance of experimental work on the intestines. Not only is this necessary for the general surgeon, but also for the gynæcologist, who enters the abdomen. This work differs so essentially from other surgical technique, that, without practical experience, the general surgeon is no more fitted to do it than he is to operate on the eye. Such experience can be readily obtained by practicing on the human cadaver, and, better still, on the lower animals, preferably dogs. If we exercise the same care with the latter as with human beings, we cannot be charged with cruelty, and will train ourselves to that scrupulous attention to detail so essential to success.

It would seem desirable that we should have in each section of the country one or more men familiar with intestinal technique, and ready to treat those emergencies so often met with, such as obstructions, internal and external, perforations, etc. In this way these conditions would be more generally and quickly recognized, and the life-saving treatment carried out without delay.

SYNOVITIS.

LANDRETH W. THOMPSON, M.D., PHILADELPHIA.

In selecting this subject I shall refer to no one special case, but rather to that large class of cases which are so frequent, not only in the practice of the surgeon, but have been seen by all of us, whatever the branch of medicine we may be pursuing. More particularly I wish to consider a few points in the diagnosis and treatment of fluid accumulations within synovial membranes, with a view of emphasizing and insisting on some of the more important points in connection therewith.

The diagnosis as to whether or not fluid be at all present in the joint in fresh cases, uncomplicated with much bruising of surrounding tissues, is quite simple, as where you see an ordinary sprain. In these cases you can almost see the pouting of the sac. It is an excellent plan to give even these very simple cases a most thorough examination. Such a course familiarizes us with the sharpness of each anatomical detail, and will make our subsequent examinations more easy and more certain. Here, of course, we find sharply defined the heads of the bones forming the joint, the prominences to which ligaments are attached, and the ridges running from them.

If, however, the case be progressing beyond a simple synovitis, and the cartilaginous portions of the joint are becoming involved, we will find, from the patient's description, a greater soreness about the joint, not alone the pain of a distension, but also an actual diminution of mobility. Then, too, as your fingers follow up to the extreme ends of the bones, you will be able to detect, usually, a greater sensitiveness of the cartilaginous surface than when pressure is made on a simple distended synovial sac. When the entire joint becomes involved, we note again the character of pain, which is more decidedly an ache, and frequently exhibits the nightly exacerbation. Examination of the joint now shows inflammatory infiltration of the surrounding tissues—beginning in the periosteum and eventually involving the whole structure, which will be recognized by the general swelling of the whole

joint, the loss of the normal sharpness of the bony outlines, the presence of deep pain in the bone itself, and, after abscess formation, the ability to detect rough, bare bone. If the disease be what is spoken of as pulpy degeneration, or, more strictly, tubercular disease of the joint, we may very rarely be able to detect the erosions of the cartilage or even the soft granulations themselves; but as these occur almost exclusively at first in the deeper and more protected parts of the joint, our diagnosis will depend much more confidently upon accompanying symptoms. All of these more chronic cases of synovitis carry with them an element of doubt, and this is strengthened by quite a large number which it has been my privilege to see operated in one or another way. The synovitis seems frequently to be rather secondary to the bone involvement and due to infection from that source. Further studies of the varying forms of osteo-myelitis will throw light upon that subject.

In the treatment of these cases I have only time to mention two or three points, which, while commonly known to us all, we are often not careful enough in applying to get the most beneficial results from their use.

First, the application of cold to the joint. As readily understood, cold produces a constriction of the vessels; by its spasmodic action tightens up the interstices through which serum is exuded, and closes up the spaces in which the exudate lies and thus lessens the swelling and subsequent inflammatory changes. To be beneficial this must of course be employed very early and must be discontinued when the exudation is completed. Unfortunately, in practice, the application is usually defective, and thus the benefit is lost. A little piece of handkerchief is wrung out of cool water, placed on the limb, held there with the hand, and is heated through in a half minute. If, on the other hand, our directions are explicit in regard to the method employed (which, of course, must be varied largely according to the patient's age and physical condition), we shall have less swelling and consequently a more speedy return of function in the part. In these cases it is not infrequently difficult to say whether the swelling be due to fluid in the synovial sac or in the tissue surrounding it. We are told to decide by "tapping the patella." To do this efficiently one little

hint may be of service, viz.: fix one side of the patella against the femur, the leg being fully extended; then with your finger tap the *free edge* of the bone and its click against the sublying bone shows the distension of the joint.

The second point in treating fluid accumulations will be the pressure employed. This must be employed through evenly applied bandages and the intervention of a suitable elastic medium. The bandage should best be made of flannel, or possibly rubber. The elastic medium may be absorbent cotton, such as you will have in your office, or prepared wool, which makes a more perfect distribution of the pressure. Here again let me speak of only one point, and that is for you to actually know that the joint is supported in every direction. One or two turns of a strip of muslin will not accomplish this. No matter how small, a glove or shoe can be worn over it. Four days' rest of an acute synovitis, with efficient support, may save your patient days and weeks of after-pain.

The last point is the *immobilization*, which is accomplished only imperfectly by such dressings as above. On the other hand, wooden or metallic splints do not rightly adapt themselves to the contour of the part; hence, plaster-of-Paris fulfills much more accurately the indications. Even this requires frequent renewals, for thus only can we closely follow up the gradual decrease in the swelling and accommodate our dressing to the varying exigencies of the case. At the wrist, your patient will naturally object to the bulk and appearance of the dressing; but persistence will amply repay your efforts. I have in mind two cases of traumatic arthritis of the wrist (one six months and the other one month in duration) where just the means I have urged have given most excellent results. Even where the patient is surely infected with tuberculosis, we can often secure at least a temporary stay in the progress of the case. In fact, I am just on the point of discharging from the Children's Homœopathic Hospital of Philadelphia a little fellow who came to us a year and a half ago with tubercular deposits at both apices, ill-nourished and evidently on the down-hill. He had distinct synovitis of the right knee, which, so far as one can judge, would undoubtedly have become tubercular. The good food and close attention of our residents, with

carefully adjusted casts, frequently reapplied, have caused the most marked improvement, so that now he has almost no symptoms of even the slightest trouble with the affected knee.

DISCUSSION.

Dr. Snader reported having seen a case at the Children's Hospital, in Philadelphia, in which a plaster cast was used on the knee, and anchylosis resulted, a usual sequence. At that time it occurred to him that in similar conditions the use of extension to keep the approximating surfaces of the joint separated one from the other, while the cast is being used to secure pressure and immobility, so as to prevent the formation of firm adhesions when the fluid is absorbed. He believed with that conjoined extension the adhesions that would form would be light, and could be easily broken up, and a less formidable operation than the usual one for breaking up adhesions be secured.

Dr. Willard said that in these cases in the Pittsburgh Hospital complete rest was the treatment. Extension was made, and a cast of either plaster-of-Paris or starch was applied. In the early stages heat was used. We never use cold. We use a warm poultice, keeping up the application until all the inflammation has disappeared. Then we use the immovable splint. The patient must exercise prudence in the use of the part for months or even years, exercising with great care.

Dr. Thompson deprecated the use of the soft splint, as we are apt to continue it too long. Neither is it advisable to use a movable splint. In speaking of the use of cold applications, he referred to the treatment during the very first stages.

NOTES ON THE NEW CITY HOSPITAL, HAMBURG, GERMANY.

J. H. M'CLELLAND, M.D., PITTSBURGH.

On the last of August, 1891, I happened to be in Hamburg, on my way to Berlin. I had heard some talk of the new hospital, but recently finished (1889), of which the half had not

been told me, and so determined to stay over a few days for the double purpose of studying the construction and sanitary arrangements (as a Board of Health Commissioner), and to see some of the work done, especially by the distinguished surgeon-in-chief, Dr. Schede. I was fortunate in both missions, and, thinking that the State Society would be interested in such a matter, I have made running notes of some impressions received. This is an era of hospital building.

Upon sending my card to the Director-General, Professor Dr. Kast, I was very kindly received, and by him shown through the Central Administration building. This, I soon discovered, was a model of its kind, and thoroughly adapted to the transaction of the enormous business incident to an institution of this magnitude. An army of clerks were busily at work, and in the pharmacy and pharmaceutical laboratory adjoining, the chief and many assistants were engaged in compounding and dispensing simples and compounds. System pervaded everything and everywhere.

Herr Director Kast, who, by the way, speaks English better than most of the English, has evidently been selected for the responsible position he occupies on account of his peculiar fitness for the place. Not only is he an accomplished medical man, but his executive ability—so I am informed—is of a very high order, and upon every hand one finds evidence of this fact.

To inspect the various wards and departments, Professor Kast now handed me over to one of the resident physicians, and I was most fortunate in having for my "guide, philosopher and friend," Herr Dr. Reiche, who was most untiring in explaining all pertaining to construction, methods and management, and that, too, in a most agreeable and intelligent manner.

The great Hamburg Hospital, or, we may say, system of hospitals, is upon the pavilion plan, and we find an aggregate of some sixty or seventy buildings in all. The pavilions, for the most part, are but one story, are of brick, and of good style. The Administration building is rather an imposing structure, and the Director's residence, at a little distance, is large and pleasantly situated.

The general plan is as follows: A central avenue divides the men's and women's pavilions, and there are smaller avenues cross-

ing at right angles. Centrally located are buildings for general purposes, such as the reception and distribution of patients, the operative clinic, the bath pavilion, etc., while at a considerable distance from the main group is the mortuarium, with a pathological laboratory connected.

All patients go first to the reception pavilion, in charge of an experienced interne, who makes a provisional diagnosis and assigns them to a ward.

The operating pavilion is fitted up with every appliance necessary in the way of instruments, apparatus, and dressings. Even the operating table is heated by steam or hot water. Light is secured by windows, gas, and electricity. The floors are concrete and the walls may be washed down at any time.

The bath-house is furnished with every facility for baths of every description, electric, medicated, and continuous. In the latter I found persons who had been literally "in the swim" for two or three months without intermission. These were cases in which the sphincters were ineffective, and the steady flow of water in and out of the tubs prevented all disagreeable odors or conditions. The floors are of concrete, and the walls, to a height of five or six feet, are of tile. At this point I might explain that all floors are of concrete in these buildings, and as no rugs or carpets are tolerated, I was at a loss to know how bare feet and cold floors were harmonized. Inquiry led to the explanation that *all of these floors are heated.* By a system of steam pipes underneath the floors of all wards, bath-rooms, etc., they are kept at a comfortable heat, so that patients may walk in their bare feet without discomfort or danger of ill-effects. An admirable, but very expensive, method of heating.

I have mentioned the mortuarium. Here I found every arrangement for methodical dissections. In the adjoining laboratory, however, was to be found the perfection of arrangements for pathological research, microscopical and bacteriological, and it is here that much original research is pursued and valuable results obtained.

The ward pavilions are simple in arrangement, securing light, heat, ventilation, and administration. The windows are furnished with transoms, *i.e.*, small glass slats. Heat is furnished in part

from the heated floors, and partly from ducts extending to the hot-air chamber underneath. Ventilation is further secured by the opening along the comb of the roof, which is controlled from within by shutters. The whole system of drainage is modern and admirable.

An excellent provision for each pavilion is the dying-room, or a room for very sick patients, also a room for noisy patients. Further than this there is provided a separate pavilion for patients who continue to be noisy and likely to disturb others. Pity it is that such humane arrangements are only attainable where space is plenty.

Cupboards are found in all the wards for dressings and medicines, as well as certain instruments in daily use. A key is furnished each nurse. Another cupboard contains the more poisonous drugs, and the key to this is held by the internes only. The bedsteads are of iron and the mattresses of wool. The ward capacity is thirty-two to forty beds.

I have omitted mention of an excellent feature of the bathing arrangements, *viz.*, the bath-tubs on wheels. With these a bath may be administered at the bedside when necessary. The economic building, where the laundry, baking and cooking, and such like is done, is at the far end of this village of buildings, but they manage to get the food into the various pavilions in pretty good shape.

When we consider that here are accommodations for two or three thousand patients, that some 22,000 are admitted in one year, representing over 700,000 days, and at a cost of over a quarter of a million dollars, we may realize the magnitude of the work so successfully conducted by the Director, Professor Dr. Kast.

Upon invitation, I took another day to see something of the work of the surgeon-in-chief, Max Herm. Ed. Wilh. Schede, M. et Chir. Dr., whose fame as a surgeon I learned before crossing the water. Walking the wards with him, in his morning rounds, I saw many interesting cases and noted the general *modus operandi.* We were shown some remarkable results, especially in orthopædic practice.

Going later to the operating pavilion, I had the good fortune to see Schede resect a portion of the rectum for carcinoma. The pa-

tient was a very large, fleshy woman, and, apparently (and I so understood from the professor), was in good health. The mass and consequent stricture was probably three inches from the sphincter. The operating was done from the back, by a long incision down the sacrum and coccyx, which latter was removed to clear the way. By careful dissection the rectum was reached and the morbid mass secured, without much hæmorrhage. After removal, the tedious bit of work of reuniting the rectum was begun and finally finished with rare care and precision. The peri-rectal tissues were gathered up here and there with catgut (all sutures and ligatures were with catgut), in order to secure support, and then the immense wound, even anterior to the rectum, was packed with iodoform gauze. To conclude with, an artificial anus was established in the left iliac region, so that all discharges would be diverted from the rectum, and this was to be continued for two or three months, when the artificial anus would be closed. A couple of hours were consumed in this remarkable operation (by which the sphincters are left undisturbed), and I counted myself fortunate in having witnessed it at the hands of the distinguished Hamburg surgeon, Schede.

REPORT OF THE BUREAU OF OBSTETRICS.

Bandaging the Baby, by Z. T. Miller, M.D.
Treatment of the Umbilical Cord, by J. R. Horner, M.D.
After-Pains, by O. B. Gause, M.D.
The Means of Preventing Perinæal Laceration, by Theo. M. Johnson, M.D.
A Case of Obstetrics, Complicated by Appendicitis, by Leon Ashcraft, M.D.
Mother's Milk—A Few Suggestions to the Busy Practitioner, by J. H. Hamer, M.D.
Puerperal Convulsions, by S. W. S. Dinsmore, M.D.
Post-Partum Hæmorrhage, by H. Clay Chisholm, M.D.
Remedies in Labor, by John L. Ferson, M.D.

BANDAGING THE BABY.

Z. T. MILLER, M.D., PITTSBURGH.

BANDAGING a baby after the navel has sloughed off is an *art* in midwifery that should be condemned to the realms of the *lost*.

I do not believe in it; there is no necessity for it; hence the utter uselessness of the practice. Doctor So-and-So says this; Doctor So-and-So says that, will find no space in this paper.

When the cord stump heals, there is no physiological, anatomical, or mechanical necessity for the child to be bandaged like a broken leg. On the contrary, physiological, anatomical, and common sense reasoning tell us that the whole trunk of the "bud of immortality" should be free to sway in every direction, allowed all the breathing and trunk motion of which it is capable every hour of the day or night.

Bandaging does not strengthen a child's back; it weakens it. Supported muscle is always flabby, pale, and weak. Exercised muscle is ruddy and ready. Bandaging does not prevent rup-

ture; it causes it. The effort of sneezing, coughing, in a bandaged child, forces the abdominal contents upon the abdominal rings, and, if they are weak, rupture surely follows; whereas, if the walls of the abdomen were toned by use, and gave way in the direction they should during those efforts, many an abdominal cavity would remain above the pubes instead of hanging down between the legs, thus crowding its neighbors.

Rickety children, poor, puny, fore-ordained, are the ones most sinned against in the bandaging way. In truth, they are the very ones that need it least. Fresh air, proper food, free motion, and less compression would give such children a lease on life that is now squeezed out of them. The Italians swaddle their babies from shoulders to feet, "to make 'em strong, you know," yet Lilian Spencer says there are more bow-legged people in Italy than in any other country she ever visited.

DISCUSSION.

Dr. J. C. Sanders said that the Society had now entered a field of work with which he might claim to be reasonably familiar. If there was one point about which there has been discussion pro and con, it was that on which the author has written his paper. In general, the baby should be bandaged, but, as a rule, this bandaging has been carried too far; that is, the bandage is too tight,—altogether too tight. It should give a reasonable amount of firmness and pressure, but the main advantage of the binder is not to bind; it is to keep warm and protect the delicate surfaces from external influences. If the bandage is tight, the strain in coughing is necessarily forced directly against the rim of the navel, and thus harm is done. This general advice obtains also as regards the waist of the skirt. This also should have great laxness, and should not of itself act as a binder.

TREATMENT OF THE UMBILICAL CORD.

J. RICHEY HORNER, M.D., ALLEGHENY.

At first thought this subject may appear to be quite a simple one, but when we consider the structures involved, and the influence for disease or health careless or careful attention to the cord has upon the newly-born child, it will be seen that the subject is one which requires some degree of consideration.

The first question to be considered is, when to cut the cord. So soon as the expulsion of the child is effected, and, indeed, before that, respiration in the infant is established, and the blood begins its new course through the lungs. This relieves the necessity for a supply of oxygenated blood from the mother to the fœtus. It is the practice of some obstetricians to cut the cord as soon as convenient without paying much attention to its pulsations. It is to me an obvious fact that this procedure should be delayed until all pulsation has ceased. There should be a good and sufficient reason in either the condition of the mother or that of the child which should warrant us in severing the cord during the continuance of pulsation.

Where should it be severed? About three inches from the abdomen of the child. And this brings us to another important point, viz., the tying of the cord. This should be done at two points, about an inch or perhaps an inch and a half apart, the point of cutting being directly midway between them. What shall we use? Many things have been suggested. Perhaps the most ordinary one is the common white cotton twine. From this we go up the grade to the cotton thread, silk thread and cord, and on up to the solid rubber cord. Sometimes the umbilical cord, instead of being from one-third to one-half inches in diameter, will be twice or three times that thickness. Then you will need the rubber cord. Take a match, lay it lengthwise on the cord, tie the rubber tightly around both, then break off the match on each side close to the rubber. Thus you will have a ligature which will absolutely prevent hæmorrhage.

Then strip the cord for about two inches toward the maternal end, and tie, as before suggested, a second band of either rubber or other material. It is better to always tie the cord in two places, if for no other reason than that it gives bulk to the placenta, and the after-birth is thus more easily expelled. There, too, is the matter of cleanliness, which should be always taken into consideration.

Another point which has been discussed is as to the kind of knot which shall be used. The surgeon's knot is by far the best and safest, though the ordinary reef knot will nearly always answer.

After the cord is severed, it is a good plan to take off the band which is around the cord next the abdomen, strip it so as to get away the quite considerable quantity of Wharton's jelly which is contained, and then retie it. Thus you further the dry gangrene, besides lessening the size of the stump.

The dressing for the cord should be wool wadding. It is by far the cleanest, neatest, and most absorbent. The antiseptic cotton is very good, but the wool is its superior, because it does not cake or become hard should the discharge be at all free. The dressing should be very carefully applied, the stump of the cord pointing upward on the abdomen, and lying on a piece of the wool which has been folded to the proper shape. Over this is placed a larger piece, so as to thoroughly cover that which is under. Over all is the binder, which should be firm and warm, but neither too tight nor of too heavy material. In many instances the persistent crying of an infant may be found to be due to heavy clothing, and particularly because of the heavy band. So watch this little point, and you may be saved an extra trip or two.

Desiccation will usually be complete on the fifth or sixth day, though I have at times had the stump entirely loose on the third day, while in one case the cord was enormously thick, probably more than an inch, and it was obliterated by sloughing gradually from the cut end to the abdomen, occupying, in so doing, a period of perhaps three weeks. After the cord is completely disconnected, apply a small wad of wool to strengthen the parts and prevent a hernia, and to absorb any discharges which may occur.

Since writing the above, I have read an article in the *Journal*

of Obstetrics, written by Dr. Winterbottom, of New York. In this article he has made a very complete *résumé* of the results of numerous experiments on the effects of early and late severing of the cord. It is claimed that there is a very considerable difference in the health of the child when the cord is severed early. After a long series of experiments touching the point, it was found by one observer that there was a difference of three ounces of blood in favor of the child when the cord was cut late. That is, three ounces more, on an average, flowed from the placenta when the cord was cut late than when the cord was cut early. So in early cutting of the cord the child was deprived of this three ounces of pure, oxygenated blood, which was ready to be transferred from the mother to the child. This is about one-fifth of the entire amount supposed to be contained in the whole circulation of the infant, and forms, as you see, no inconsiderable amount.

Other observers have followed up this line of investigation, and with only one notable exception have come to a conclusion similar to that quoted above. This one observer claimed that it is not good policy to delay cutting the cord. It should, according to his ideas, be done immediately. He argued that infants, as a rule, are plethoric, and when delay is made in cutting the cord they are more prone to jaundice, vomiting, etc. But his views are not warranted by general experience. After late cutting of the cord the child is rosier, healthier, cries less and sleeps more, and requires nourishment later than does the child after early cutting.

It is very good practice in cases where the infant is feeble and poorly nourished, to apply artificial heat to the cord, and thus lengthen the time during which the blood flows through it. It has been demonstrated that the blood ceases to flow from the arteries sooner than it does from the veins, this being presumably due to the quicker action of the cool air on the arteries than on the less susceptible veins. Consequently there is less blood flows from the body of the infant through these arteries than flows to it through the veins, and there is a consequent gain in the amount of rich blood in the infant circulation.

So let us have the cord cut at the last possible moment, surely not, under ordinary circumstances, until after pulsation ceases.

DISCUSSION.

Dr. W. J. Martin said that the tying of the cord in two places was not in accordance with the recommendation of some physicians, who advise that it be tied in one place, that is, next the child, and allowed to drain. He reported having noticed, and in several instances having acted upon, the advice that, when the child was asphyxiated, we should direct the mother to take a number of deep inspirations. The effect will be to stimulate the child and establish respiration in the little one.

Dr. Holcombe did not think it a matter of importance as to what the dressing for the cord should be. He first used ordinary scorched linen, after that took up the use of cotton, then wool, and now is indifferent as to the dressing, or what it consists of. He, too, cuts the cord as short as possible, and ties with anything that happens to be at hand, using but one ligature. He uses Terry's pad of rubber in all his obstetrical work, placing it in position just before the last expulsive pain.

Dr. H. J. Evans failed to see how at that stage of the case, the pad would have any protective influence. It is practice to allow drainage, using but one ligature.

Dr. Dietz deprecated the plan of cutting the cord close, and advocated the use of two ligatures. He does not use silk in tying.

Dr. Schmucker said that there were varied practices in the matter of both cutting the cord and dressing it. One method is not always applicable. The important matter is to consider the saving of the child discomfort, and the maintenance of cleanliness. It is not his habit to strip the cord at all, and in dressing he uses cotton batting. In order to insure against the odors of decomposition, he is in the habit of using iodoform, sprinkling a small quantity of it upon the part, and covering it up thoroughly with the cotton.

Prof. Sanders approved of the general tone and instructions embodied in the paper. It is not essential what the material is with which the cord is tied. We must be careful about the length of the cord. The umbilical vesicle has been known to project into the cord a full inch, and, therefore, the severing must be done far enough away to avoid all possibilities of injuring this important

part. With regard to the time of the application of the ligature this may be done prematurely or delayed unnecessarily. The condition of the child must determine as to the time of ligating and severing the cord. If it is dead, it makes, of course, little difference. If asphyxiation is imminent, and the child struggling for breath, wait till respiration is thoroughly established, and the color of the skin is natural. When there is profuse hæmorrhage from the mother, the cord must be cut at once. With regard to the cutting of the cord when it is brought down about the neck of the child, I should say it must never be done. The first thing to be determined after the birth of the head is as to the presence or not of the cord around the neck. If it is there, careful tension should be made so as to lift it over the head. If the cord is not beating, delivery must be effected at once, either by demanding a pain from the mother, or by friction over the uterine fundus, or both. But never cut the cord, except as a *dernier ressort.* Again, we may cut the cord for the promotion of respiration, in case the child is asphyxiated, and the cord still beating. Now cut it at the proper place, and allow the discharge of a tablespoonful of blood. Sometimes this will establish respiration when every other expedient has failed. He has verified the method of inducing respiration as suggested by Dr. Martin. With regard to the dressing of the cord, the ideal dressing is wool. Iodoform is not at all necessary. If it is cut at the proper length, and dressed in the proper way, there is no offensive odor present.

Dr. Holcombe said that his experience as given was the result of his observations during twenty years of practice. He did not wish to be understood as saying that it was a common thing for him to cut the cord without tying, but only as a *dernier ressort*, when it could not be brought over the head.

Dr. Seip called to mind that some years ago a paper was read advocating simple severing of the cord, without either tying or dressing. With regard to the idea advanced that through injudicious stretching while endeavoring to get the cord over the head it might be torn from the abdomen, he would say that during his own experience, covering some twenty-three years, he had never known it to occur. A very important point in the dressing is to use something soft. He called to mind a case in which he

was consulting physician, where trismus developed, and caused death. On examination, he found that the trouble was due to a badly tied cord; that they had used a piece of old linen partly charred, on which a little blood had oozed, coagulated, hardened, and by its irritation caused trismus.

Dr. Schmucker reported having had a case where the cord was torn completely apart about three inches from the abdomen, this being due to a wrapping of the cord about the neck of the child.

Dr. Sanders said that it is difficult to effect delivery with the cord about the neck of the child, and it always causes great delay.

AFTER-PAINS.

O. B. GAUSE, AIKEN, S. C.

From the commencement of gestation to the induction of parturition, there is an extra physiological work superadded to the personal physiology of the individual.

This extra assignment is characterized by a peculiar definiteness, inasmuch as it must be completed within a definite number of days, with scarcely more margin than a commercial bank notice for payment of a maturing note. In the whole realm of physiology we find no other phenomena thus characterized. Reproduction stands alone for study and admiration. From the hour of conception every step is fraught with an absorbing interest, scarcely less than the final one, when a new human being, endowed with all the possibilities of immortality, enters on its mundane career. During the two hundred and eighty days assigned for the completion of this enormous contract, the work goes on without any cessation. It begun suddenly and will end abruptly.

Though sudden in its inception, it is as gentle as the falling dew. For thirty days there is neither sign nor token manifest that anything unusual is transpiring. Not so with the abrupt close of gestation.

The sudden eruption of a volcano, an earthquake or a cyclone is not more disturbing to the usual terrestrial quietude than is the phenomena of parturition to the tranquility of ante-maternity. The pangs and throes of "labor" have passed into literature as typical of the intensest human physical suffering. Much of the sacredness of motherhood finds its root in the birth-pangs; but there is more than pain—there is peril—and it is to be borne in mind that neither the pains nor peril cease with the termination of labor. It requires a greater or less period of time for the system to readjust itself after the sudden emptying of the womb. The immense vascular supply required for the sustenance of the fœtus, especially towards the close of gestation, is an ever-present source of peril. To divert this into ante-pregnant channels is the work of days. It is during this isthmus of time that we have the phenomena of after-pains. They begin so soon after the extension of the placenta, that they may be regarded as a part of the parturient phenomena, made imperative by the urgent necessity of cutting off the vascular afflux to the uterus and the cleansing that organ of the remaining secundines. After-pains are, therefore, a physiological part of parturition. As such they extend over a variable period of from one to three or four days, or as long as *relaxation* succeeds contraction.

Very soon after the completion of labor the parturient woman suffers in a greater or less degree, according to the severity of the labor, from shock; in severe cases, with rigors and general prostration. Measurably, at least, will the delay in the onset of the after-pains depend upon the severity of the shock. As a characteristic of shock is depressed heart-action, there is by so much diminished danger from flooding. It is well, however, for the accoucheur to bear in mind that that danger menaces his patient until normal after-pains are fully established. It is at this point we recognize the beneficence of after-pains. When once established they will recur at frequent intervals for several hours, until the engorged meshes of the walls of the womb have been emptied and the constrictive effect diminished the supply of blood; then, as the tonicity of the uterine walls returns, the *retractile* property of muscle begins to relieve the contractility; the contractions become less frequent; the womb becomes dense and firm. So that

by the third day it may require the sympathetic irritation of the nursing child to arouse any after-pains.

I have thus sketched rapidly and briefly the cause, origin and duration of physiological after-pains. At this point the parturient act may be considered complete and the parturient woman enters upon the stage of convalescence and lactation.

There is no other physiological function where there are more marked departures from what may be considered normal than in child-birth. This we find in every stage of parturition. As regards after-pains, we find variations in duration, in character and effects upon the general condition of the lying-in woman.

A few years' experience will cause the active obstetrician to marvel why so little is said in the average text-book on obstetrics on "after-pains." The greatest sufferers from after-pains are persons of a rheumatic or neuralgic diathesis. This being known may be treated in advance of labor, with a fair expectation of lessening the sufferings after the close of the third stage of labor.

In typical normal labors all fæcal accumulations in the lower bowels are spontaneously evacuated before labor has advanced beyond the first stage. Where this is not done spontaneously it should not be overlooked by the accoucheur, as the retention may prove a hindrance to labor and an unpleasant irritant afterwards. In a larger per cent. of cases of spasmodic and irregular after-pains there will be found a distended descending colon and rectum. In such cases, in addition to the remedy symptomatically chosen, a liberal tepid injection will wonderfully relieve. The early application of the child to the breast will help to regulate and shorten the duration of the pains. In seeking for the appropriate Homœopathic remedy it will be well to take a *broad* as well as a minute view of the case—the totality as well as the individuality. Pains that begin suddenly and end suddenly with suffusion of face and hot discharges point to belladonna, and, with these symptoms, a desire to have her bowels evacuated, to nux. It will scarcely be wise to give belladonna or nux separately or in alternation, at least until an enema has been given. In cases that resist all therapeutics—for now and then such cases arise—as a *dernier ressort*, recourse may be had to anodynes. The best method in such extreme cases is tepid water with a little laudanum, or a sup-

pository with an one-eighth or one-quarter grain of morphine. Neither of these extra Homœopathic remedial measures are likely to do any harm and may afford immense relief at a time when *pain* is an unavoidable evil. It is not the province of this paper to elaborate the therapeutics best adapted for the treatment of after-pains, but I trust I may be pardoned for referring to the treatment that I have found satisfactory in extraordinary cases.

A more serious complication than a loaded rectum is a full bladder. This is the most painful complication of labor. It is most liable to occur during the second and third stage, and is liable to escape detection. It is characterized, in the second stage, by an exquisite sensitiveness during the expulsive effort. The patient will shrink back, as it were, from every pain. She cannot render the usual voluntary effort to assist expulsion. If at this time an examination above the pubes is made, there will be found a tumor that may be outlined as distinct from and in front of the uterine tumor. If the urine be drawn, the labor will go on easily to completion. If the retention sets in a few hours after the close of the second stage, it is still liable to escape detection.

As the urine increases, the pains and sufferings increase in severity. The patient becomes restless and feverish; the sufferings are continuous, with occasional aggravations, due to the real after-pains. An abdominal examination at this point will give signs of peritonitis. The patient will be hot, restless, and most likely be bathed in a hot perspiration; face red and eyes suffused. The whole picture is one of great distress. The lack of special tenderness on palpation will exclude peritonitis, and an abrupt fulness *immediately* above the pubes will lead to the introduction of the catheter. This will solve the mystery and afford prompt relief.

Too great care cannot be exercised by the accoucheur in watching the renal secretions.

Excluding rectal and vesical complications, there remains an occasional case of severe, uncomplicated after-pains, pure and simple.

Such cases must be due to a constitutional dyscrasia, to be met by therapeutic means as distinct from measures of relief as in the foregoing complicated cases. Even in these cases, if one fails to

promptly find the true similimum, it may not only be justifiable, but duty, to resort to palliative measures. It is the duty of the physician to *relieve* suffering and cure the sick. The hypodermic syringe, charged with sulphate of morphine, will not cure. Chloral will not cure, neither will the administration of either or any of the numerous relief remedies cure. But for that reason shall we, as Homœopaths, be compelled to deprive our patients of present relief because we know relief is not cure? This cannot be justified except on the assumption that such relief will jeopardize the cure. I am quite confident that this is not the case in after-pains. If there is a rheumatic or neuralgic diathesis back of the outbreak, it is our duty to treat that if we would effect a cure.

From the foregoing, we conclude that after-pains are a physiological part of the third stage of labor, and only require treatment when excessive in character or of prolonged duration. That in every such case it is the duty of the accoucheur to determine whether there are any complications that necessarily aggravate what were else normal. The aggravations due to nursing may be modified or entirely removed by the wisely chosen Homœopathic remedy.

DISCUSSION.

President Korndœrfer said that it was unfortunate that the author had spoken of remedies which were not strictly Homœopathic in their action. He thinks that this is a great field for pure Homœopathic treatment. He referred to the use of cuprum metallicum, especially for multiparæ. Cuprum 2c relieved a patient whose condition had become desperate. The prescription was recommended by Dr. Hering, and the special indications were pains which were violent and distracting. He thinks it a great deal more reliable than morphine.

Dr. Z. T. Miller verified the use of cuprum in this condition.

Dr. Ferson does not give any remedy for these pains unless they become very severe.

Dr. Dietz suggested the use of actæa racemosa for after-pains which extend from one side to the other. He advised the use of the higher potencies. Viburnum is another good remedy. Arnica,

the universally given remedy, in his opinion does prevent the pains from coming severely. Rhus toxicodendron also is often indicated in this condition. It was recommended by Farrington.

Dr. Duff called to mind a case which came under his care, after having been treated for some time by physicians of the Allopathic school. By the careful prescribing of Homœopathic remedies he was enabled to relieve the condition entirely, though the patient had been informed by her physician that she could not possibly recover.

Dr. Chapman always gives arnica to her patients after parturition, and has to deal with but few after-pains. She gives, also, ferrum phosphoricum where the pains are extremely severe and are associated with a rise in temperature. In tedious cases there is often great suffering. In primiparæ, where there is severe suffering and a nervous condition, she finds that arnica controls it.

Dr. Bowie said we must take the mental condition into consideration. He would prescribe chamomilla for a patient who is cross and irritable, pulsatilla for one who presents the well-known pulsatilla temperament, and belladonna for a condition presenting a flushed face and headache. In all his prescriptions he is guided a great deal by the mental condition. He never uses morphine.

Dr. Dietz said that it was a very important and dangerous condition when the after-pains are accompanied by febrile symptoms. We must look out for inflammatory development, and take proper precautions to prevent disastrous results.

Prof. Sanders characterized the paper as being very interesting, but in its main propositions entirely at variance with his own ideas and experience. He does not regard an after-pain as being physiological. It is pathological. For, if purely physiological, what is the philosophy of all this therapeutic advice? If it is physiological, let it alone; if it is pathological, treat it. It is pathological, because primiparæ do not have after-pains. They come only when the uterine force is exhausted. There are several kinds of after-pains, and consequently different treatments are required. We have the neurotic conditions, which require remedies from a class different from those used in the treatment of pains of other origin. They may be rheumatic, that is, occur in a subject

of rheumatic diathesis; and again, they may be due entirely to a mechanical condition, as, for example, the retention of a blood-clot. It is to effect the expulsion of this foreign body that uterine contractions are excited.

A MEANS OF PREVENTING PERINÆAL LACERATIONS.

THEO. M. JOHNSON, M.D., PITTSTON.

It is not the intention in this paper to go over all of the various means of preventing laceration of the perinæum during labor, but to give a short paper presenting my experience on the subject, because I believe I can claim to have been successful in preventing lacerations. The discussion, I hope, will bring out more upon the subject.

I think I have only heard of one physician who uses the means in which I place most confidence, although there may be many such.

We are taught that when the fœtus impinges upon the floor of the perinæum, there begins a stretching process in that region, and that the fibrous tissues must have a little time to be acted upon or else they may tear before they are stretched sufficiently. Furthermore, that if the labor seems too rapid and forcible at this stage, it is well to impede it by pressure from before. I believe this principle is correct.

However, instead of impeding labor, we may accelerate it, and be more sure of preventing laceration than by the above plan in most all cases. Like any other procedure, there will, at times, be emergencies which will have to be provided for otherwise.

My usual method is, while sitting at the patient's back during the second stage of labor, to insert the first, and, later, the first and second finger in the vagina, flex them a little, and make backward traction upon the perinæum from within the vagina. The

traction should be forcible during a labor-pain, and simply hold what you have gained between pains.

Of course, this is not generally kept up all through the second stage, but can be sufficiently to have almost paralyzed the perinæal muscles. I have done considerable of the required stretching, and rendered pliable the skin and mucous membrane, thereby, to a *great* extent, overcoming the liability to rupture.

As far as my own experience goes, it seems to me to be *unnecessary* to ever rupture the perinæum. I have practiced this method for six or seven years, and have had but one laceration. That case was the last day of last March, and one of the most trying instrumental deliveries I ever had. Having brought the head down to a point where one or two more such pains as the woman was then having would, as I thought, deliver the child, I took off the forceps, and, by my own carelessness and impatience, I actually tore the perinæum with my finger in an effort to unbutton, as it were, the almost delivered head, by running my fingers around inside of the vulva.

On account of the case being an instrumental one from an early stage of the labor, and requiring continued and great outlay of muscle, I had altogether neglected to use my usual precaution against rupture, regarding it as of minor importance. One stitch repaired the injury.

Most patients seem not only to have an idea they are being assisted by this operation, but they seem to have a *sense* of being helped, and will sometimes even ask you to continue if you cease your efforts for a time. Occasionally, one would like to kick you through the door if you persist. I never persist if they complain.

Incidentally, pains, if lagging, may be stimulated by making the traction referred to between pains, especially if accompanied by slowly withdrawing the fingers, thereby producing a sensation somewhat simulating the passage of the fœtus over the parts.

Probably the antiseptic doctor on this Bureau will "sit down on me." He need not, though, if ordinary antiseptic precautions are used.

A CASE OF OBSTETRICS COMPLICATED BY APPENDICITIS.

LEON T. ASHCRAFT, M.D., M.A., PHILADELPHIA.

About midnight of February 6th I was summoned to relieve a patient suffering from "cramps." Upon entering the room I saw a female, about fifteen years of age, whose anxious countenance, as she pleadingly extended her hands for help to bear such long-continued pains "hinted" the possibility of labor. Exposing the abdomen, by means of inspection and palpation a well-defined tumor was revealed. Fortunately having a grip containing armamentaria necessary to treat the case, I prepared a one to ten thousand solution of bichloride of mercury, and thoroughly laving the external genitalia and rendering my hands aseptic by using carbolized vaseline, made the touch, and, finding the anterior fontanelle somewhat to the left, diagnosed a vertex presentation, in the "right occipito-posterior position." Making a V-shaped wedge of my thumb and index-finger, and placing the hand against the perinæum, I encouraged her to "bear down." Several sharp pains were sufficient to expel the head, revealing the cord tightly wrapped around the neck. Fearing suffocation, I rapidly delivered, slipped the cord over, ligated either end, cleansed the mouth, nose, and eyes, and handed the babe to the nurse for attention. Carefully examining the mother, and finding no tear, I gave comfort by douching the tract with a weak antiseptic.

Questioning the aunt, I was not surprised to learn her ignorance of my patient's ante-partum condition, since it lacked important presumptive signs of pregnancy, such as na usea, perverted appetite, and emotional phenomena, also, "strange to say," showing very little abdominal enlargement. A history of obstinate constipation, however, materially assisted in making an important diagnosis during the lying-in period. Further questioning elicited the comparative duration of labor, the first stage occupying almost fifteen hours, the second about three hours, and the third was ter-

minated in twenty minutes. At the aunt's request, the babe, a fine boy, weighing about eight pounds, was immediately sent to a "Retreat," where, for a "consideration," it was cared for (?) until his death, which occurred several weeks later.

Calling the subsequent morning, it was no surprise to find a very weak woman, with pulse of 110, and temperature of $99\frac{3}{5}°$ F. and after-pains quite severe, the urine being passed with difficulty. The lochia was normal. The next day an alarming train of symptoms supervened. Pulse, 120; temperature, $100\frac{1}{2}°$ F; respirations somewhat increased; after-pains marked; dull frontal headache, and thirst; white furred tongue, and fœtid discharge. Bringing her to the bed's edge and separating the thighs, a weak bichloride douche was personally administered, after which napkins thoroughly powdered with equal parts of iodoform and boracic acid were applied to the vulva. I ordered a nutritious diet of liquid consistency, and administered veratrum viride 30. Improvement resulted. As the breasts were painful they were bandaged and suckled. Until the ninth day everything progressed favorably. She then had a chill, rise of temperature to 101° F., followed by sweat, severe abdominal distress, associated with obstinate constipation, the bowels having moved but once during her illness, the stool having as characteristics, straining, with passage of hard, black balls (necessitated peristalsis). A rectal injection of glycerine and water was ordered, and opium 30 given per orum. Relief resulted, but attempts at stool caused agonizing pain.

For six days nothing happened, when I was again hastily summoned to relieve pain. No comfort was attainable except the right thigh be flexed, and to maintain this position was impossible, because of vomiting and retching. Thorough examination showed a tumor in the right iliac fossa; pulse, 140; temperature, $102\frac{3}{5}°$ F.; respiration, 40; constipation. Ordered rectal injections, local applications of turpentine stupes, and the internal administration of bryonia 30x. I also discontinued all foods, hoping thereby to allay vomiting and give the patient relief. My next call found her worse. The rapidly developing tumor, excruciating pain, intestinal torpidity, associated with pulse, 140, temperature, 103° F., and respiration, 40, justified a diagnosis of appendicitis.

Deeming a consultation necessary, and obtaining consent, Dr. Van Lennep was summoned, with a view to operative measures. Deciding to await developments, we repeated the rectal injections, together with local applications, and bryonia 3x internally. The bowels moved during the night, but the attempts were invariably attended with much distress, and in the morning the pulse was 120; temperature, $101\frac{2}{5}°$ F. Continuing the same treatment, the case made fair progress until March 1st, when a return of similar symptoms warned me to continue routine treatment. The ensuing week was of grave anxiety, but, fortunately, recovery was slowly sure, and ten days later she was discharged, with careful injunctions as to diet and mode of living. One month later, I received a call "in persona," and was delighted to see an apparently healthy female.

Concerning her present condition I am unprepared to give information.

MOTHER'S MILK—A FEW SUGGESTIONS TO THE BUSY PRACTITIONER.

J. H. HAMER, M.D., PHILADELPHIA.

It frequently happens, in the course of obstetrical practice, that the suspicion of the attending physician is awakened by the symptoms or general condition of the child to the fact that the milk supplied by the mother or wet-nurse is not what it should be for the proper health and nutrition of the infant.

Under these circumstances, it naturally occurs to his mind that an investigation into the quality of the milk should be made. Some of us are at a loss how to proceed to the accomplishment of this object on account of the lack of literature upon the subject, or on account of the time and careful attention required for making an accurate chemical analysis.

It is the object of this paper to bring to your attention such simple tests for this purpose as may encroach least upon the time of the busy practitioner. It must be understood, of course, that

these methods will give only approximate results, but such as will doubtless prove of valuable practical service in the majority of cases.

It is important, in the first place, to know that the normal constituents of the milk may vary within small limits in their proportions according to varying circumstances, and yet the milk may answer all the purposes of a food suitable for the proper nutrition of the child; and upon this fact depends the value of even a rough approximative analysis, such as may be readily made in the office of any physician. But there is a certain average in the ratio of the constituents from which there should be no wide departure, else the child will suffer either from the want of a proper supply of one or more of the constituents, or from lack of ability to dispose properly of an excess of the same.

It does not fall within the scope of this paper to give the various analyses that have been made of human milk, all of which differ more or less from each other; but I would like to draw the attention of those who would, in their examination, wish to compare their results with those obtained by a similar examination of cows' milk, to several points of difference which it is important to take into consideration if such comparison be made.

First, it must be observed that human milk contains from 2 to 5 per cent. more water than cow's milk; second, from 10 to 20 per cent. less fat (cream, butter); third, about 1 per cent. more lactose (milk sugar); fourth, one-half to one-third as much of the inorganic salts; and fifth, about 15 to 25 per cent. less casein. It will thus be observed that, with the exception of water and sugar of milk, cows' milk is richer in its various constituents than mother's milk.

To make a satisfactory examination of mother's milk, as much milk as possible should be procured at one time. This may be accomplished by allowing the breasts to thoroughly fill, and then exhausting them with the breast-pump, the infant in the meantime being artificially fed.

A rough approximative estimation of the percentage of cream may be made in the following manner: Take a six-inch test-tube, paste on the outside a strip of paper five inches long, which is graded into twenty-five or fifty equal divisions from the bottom.

Each of these grades will then represent 4 or 2 per cent. accordingly. Fill the test-tube with milk to the top of the register, set it away in a temperature of about 60° F. for twenty-four hours, then take the reading of the layer of cream. It should not be much below 6 per cent.

If it be desired to determine the richness of the milk in fats, it may be done in the following manner: Place a measured quantity of milk, say ten cubic centimetres, in a large test-tube; add to this the same measure of a 10 per cent. solution of caustic potash (KHO), and agitate; then warm gently over a spirit-lamp (not to the boiling-point), set aside and allow to cool. When cool, add the same quantity of ether (10 c.c.), agitate well, so that the ether may be well mixed with it; allow it to stand until the ether rises to the top and forms a distinct layer; remove this layer to another test-tube or an evaporating-dish by means of a pipette. As the ether dissolves the oils, they are held in this solution, and may be recovered by carefully evaporating the ether with gentle heat.

If convenient, these oils may be weighed. They should weigh not far from 3.5 grammes or 55 grains for every 100 c.c. of milk used, *i.e.*, if 10 c.c. of milk be used, .35 grammes or 5½ grains.

To separate the casein, add a few drops of some dilute vegetable acid, or a little vinegar, to a measured quantity of milk; warm and filter. The casein remains as the residue, and a rough estimation may be made from this, although it contains the butter and albuminous constituents, besides the casein. If desired, the butter may be separated by digesting with ether, and the casein then dried and weighed. It should not vary much from 3.5 grammes per 100 c.c. of milk.

To determine the amount of lactose (milk sugar), add to a measured quantity of milk a few drops of muriatic acid or acetic acid; heat to boiling-point; filter; dilute the filtrate with three parts water, and examine by Fehling's quantitative test, which may be found described in works on urinary analysis.

For the salts, evaporate a measured quantity of milk on the water or sand bath; transfer the residue to a porcelain capsule, and burn away the organic matters until only a white ash remains. These are the inorganic salts, and may be estimated roughly by their bulk, or more accurately by weighing.

The proportion of these various salts can be determined only by a tedious chemical process not adapted to the private office.

For determining the presence of abnormal constituents, such as pus, blood, mucus, epithelium, etc., the use of the microscope is the most reliable means.

If the milk leaves a sediment after standing a short time, a portion of this sediment may be placed on a slide and examined under the microscope, or, if pus be suspected, it may be demonstrated chemically by removing some of the sediment, adding a few drops of a solution of KHO, or a small piece of the same in "stick." The presence of pus will be indicated by the production of a transparent gelatinous mass. If blood be suspected, a few drops of the tincture of guaiacum, added to a portion of the sediment, and then the same quantity of old (yellow) oil of turpentine, and well mixed by agitation, will indicate its presence by imparting a blue tint to the layer of turpentine, which rises to the top.

If vegetable coloring matters are present from remedies taken or administered (as rhubarb, rheum, orcina), a solution of caustic potash, added to the milk or the whey after the cheese is removed by rennet, will redden it, the color being discharged by neutralizing with nitric acid, and again renewed by neutralizing with the solution of caustic potash.

Contamination from alliaceous foods (as onions, garlic, leeks, etc.), or from cruciferous vegetables (as cabbage, turnips, etc.), may be detected by the characteristic odor of the milk.

The presence of opiates and narcotics and drastic medicines is best determined by observing the symptoms of the child and ascertaining the history of the case.

A crude idea of the digestibility of the casein of the milk may be obtained by observing the time required to digest some of the milk with essence of pepsin and hydrochloric acid. To do this, add a few drops of essence of pepsin to a small quantity of milk; warm carefully until curd is formed; then filter the curd from the whey, and to the remaining curd add a few drops of hydrochloric acid (muriatic); keep this at a temperature of about 100° F. until a yellowish liquid of a peculiar odor results. Note the time required to produce this result. Three hours should suffice.

The mental condition of the nursing mother also affects the condition of the milk, as is well known, and also her general health, both of which conditions must be met by the physician with the appropriate Homœopathic remedies.

If the milk is deteriorated from some vice of the mother's constitution, as syphilitic infection, scrofulous diathesis, tubercular tendency, etc., it is obvious that the best way to correct, if possible to do so, is to attack the general malady with indicated remedies and appropriate hygienic measures.

When the milk is contaminated with narcotics, or drastics, or tonic bitters (which latter will indicate their presence to the taste), or mercurials, or any medicine or article of food taken by the mother or nurse, affecting the milk unfavorably for the child, the remedy is obvious, to put a ban upon their use.

But in conjunction with the general condition of the nursing mother valuable indications may be derived from the special character of the milk for the selection of a remedy.

For instance, when the casein and the fats are reduced below the normal and the milk is thin and watery some one of the following remedies may be called for: China, iodium, pulsatilla, calcarea phosphorica, calcarea carbonica, silica, lachesis, cyclamen, acetic acid, carbo animalis, which should be differentiated from each other, in their exhibition, by concomitant indications (symptoms). Some of these distinguishing symptoms may be found in the character and appearance of the milk itself—others must be found outside. The consideration of the latter does not fall within the province of this paper.

If the milk, besides being thin and watery, quickly changes from an alkaline to a neutral or acid reaction, which may be determined by litmus paper (mother's milk is strongly and persistently alkaline), suggesting the presence of some abnormal nitrogenous constituent, calcarea phosphorica is indicated. If of a sour taste and odor (from a similar cause), thin and bluish, and markedly deficient in casein and fats, acetic acid. If under the microscope this watery milk shows an absence or marked deficiency of the "milk globules," pulsatilla. If thin, and of a decidedly blue color, lachesis. If thin and watery, leaving a spot like starch on linen (from presence of mucus indicating a catar-

rhal condition of the mammary ducts), cyclamen. If thin and disagreeable to the child, who refuses it or vomits it as soon as taken (perhaps from the presence of offensive discharges through fistulous openings into the ducts, from old abscesses), silica, especially, perhaps, calcarea carbonica. When thin and salty, showing excess of chlorides, carbo animalis. If the milk has the appearance of stringy masses floating in a watery fluid (mucus and epithelial cells, and, perhaps, casts of the ducts may be found under the microscope), showing also a catarrhal condition, kali bichromicum. If the milk is thick and coagulates quickly on standing, and tastes badly (indicating excess of casein and other nitrogenous matters—some, doubtless, abnormal—which set up speedy fermentation), borax. If the milk is cheesy and perhaps mixed with pus and blood, especially if it has been affected by the emotion of anger in the mother, chamomile. If the milk is yellow and bitter (which, if not due to medicines taken by the mother, may be caused by butyric fermentation in the milk), rheum ; especially if it cause sour-smelling diarrhœa in the child. For bloody milk, apis is recommended, or if the child vomits, it is lycopodium.

Bad milk from various causes may find its remedy in mercurius, borax, carbo animalis, chamomile, cina, nux, pulsatilla, stannum, asafœtida, which must be chosen according to indications.

When the milk is rendered detrimental to the child by a paroxysm of anger or other violent emotion of the mother, remedies to correct the accompanying condition of the mother's nervous system should be given, for instance, valerian, chamomile, etc.

If pus is present from any cause, as mammary abscess opening into the ducts, or profuse suppuration of fissured nipples, etc., these conditions must be combated by appropriate means, and the administration of such remedies as mercurius, graphites, hepar, silica, phosphorica, etc.

It should not be forgotten that in all cases proper hygienic precaution and suitable dietetic measures are necessary, in conjunction with medication.

When the fats or sugar are deficient, a liberal carbohydrate diet is called for, and the exhibition of some reliable malt extract. When the salts appear to be deficient, articles of diet in which

these salts are retained, as bread made from unbolted flour, are indicated. Of course, nitrogenous foods should not be withheld, or the milk may suffer from deficiency of its albuminous constituents.

PUERPERAL CONVULSIONS.

S. W. S. DINSMORE, M.D., SHARPSBURG.

MRS. S. is aged about twenty-two years; has been delicate as a girl and as a woman; had scarlet fever when about eight years of age, since when she has suffered with naso-pharyngeal catarrh, and an exceedingly easily disordered stomach. She is of medium height, spare figure, strumous diathesis, being frequently under treatment for her various ailments, mostly arising from inability to digest food, and sensitiveness to atmospheric changes. Her first child was born October, 2d, 1889. The birth was a very easy one, the child being partially delivered when I arrived at the house. It was a breech presentation. Metritis followed. The temperature went up gradually to 104° F., and then declined slowly under treatment. There was albumen in the urine. As the temperature declined, phlegmasia of both limbs ensued, which lasted five or six weeks, from which she gradually recovered. She had no nurse for her babe, and her general health was poor.

She again became pregnant in August, 1890, and seemed to have better health than usual, gaining in strength and flesh. I was called to see her on the morning of May 20th. That morning the house caught fire before she got up, and she was very much frightened. I noticed at this time that her limbs and face were swollen, but she declared she never felt better in her life. I gave her ignatia 3d, with instructions to let me know by the next day if her symptoms were not improved. I did not hear from her again until about 9 P.M. Saturday, May 30th, when her husband came to tell me that since supper his wife complained greatly of pain in her stomach, with belching of wind and some nausea, caused, as they thought, by eating onions at supper time. I sent

her some ipecacuanha 3d. In about two hours her husband came and said his wife was much worse. I found her suffering with pain in the stomach spreading over the entire breast, severe shooting pains through her head, throbbing temples, and red face, with moaning and restlessness; the pupils were dilated, and she still complained of nausea, with inability to vomit. I gave her belladonna 3d in water, a teaspoonful every half hour. Just as I was leaving the house she began to vomit, which I encouraged by giving her freely of tepid water.

She complained greatly of pain down the back of her neck, with some general pains over the abdomen. The next morning her husband reported improvement in all the symptoms except the nausea, which still remained the most prominent symptom. At his request I sent some medicine, ipecacuanha.

About 11 A.M. a messenger came in haste to tell me that Mrs. S. had a most violent spasm. When I arrived I found that she had recovered from the severity of the attack, but that her arms and legs were jerking, and froth was oozing from her mouth. Her face was purple and her breathing labored, skin hot and bathed in hot perspiration; her pupils were dilated. No answer could be gotten to my inquiries, but her father stated that it took all his strength to keep her on the bed, and she had bitten her tongue severely, and the urine had passed involuntarily.

I gave her veratrum viride, first attenuation. On examinng the womb the cervix had disappeared. The os was soft, but not dilated; the position of the child normal, and no discharge of any kind was present. I sent for a trained nurse, and had quietness restored in the room as far as possible. At 2 P.M. another attack occurred, fully as severe as the former ones, and lasting longer than either of the others. At 4 P.M. I was sent for, and saw her have her fourth spasm. I still continued the veratrum in water every half hour. In the meantime I had procured, by means of a catheter, a small quantity of urine, which appeared to contain fully 50 per cent. of albumin. I again examined the womb, and found it partially dilated, having an opening probably as large as a silver half dollar, the os very patulous, the surrounding tissues soft, and some bloody discharge, the vertex of a child's head presenting. She was very restless, tossing and moaning, and entirely uncon-

scious. In order to quiet her, I then administered chloroform freely, and in about thirty minutes succeeded in delivering her of a dead male child that seemed to be within a couple of weeks of maturity.

The after-birth was, with difficulty, removed, and I imagined at the time that some shreds remained, which afterwards proved true. They were removed by frequent injections during the next few days.

From this on the veratrum was continued at intervals of one hour. The next and last spasm occurred at 7 P.M., was less severe, and lasted but a few minutes; but full consciousness did not return until Tuesday afternoon, or about forty-three hours after the last spasm occurred. She then began to realize what had occurred. When she came to herself she complained of violent pains, throbbing headache; the pupils, which previously had been contracted and dilated alternately now remained permanently dilated. She moaned a great deal, and complained of general soreness, more particularly over the abdominal region. Her abdomen was slightly distended and tender. The lochia was extremely offensive, scant, and of a brownish color.

The prescription was changed to belladonna 3d in water every hour. Listerine and hot water were used in injecting the vagina, and plenty of tepid water in the bowels. The mammæ were swollen and tender, and the tongue was red on the edges and dry in the centre. In fact, we seemed to be threatened with almost as great danger as we had averted, but the proper remedy and good nursing soon began to have effect, and her condition gradually changed to a more hopeful one. In two weeks from delivery she was able to sit up in bed with her temperature normal, albumin almost entirely gone, no discharge of any kind, and some appetite. In fact, nothing remained as a reminder of her trouble except some slight swelling of the legs, general weakness, and free perspiration, which came out at the least exertion. Chininum arsenicum, third trituration, three times a day, for another week, cleared up the remaining symptoms, and by the first of July I was able to discharge my patient in apparently *good health.*

POST-PARTUM HÆMORRHAGE.

H. CLAY CHISHOLM, M.D., HUNTINGDON.

POST-PARTUM hæmorrhage may occur immediately after the completion of the second stage of labor, or of the third stage of labor, or may come on some hours afterwards. It is always a dangerous complication, and unless managed promptly and intelligently, may cause death in a very short time.

I agree with the writer who has said: "No physician should have the assurance or hardihood to cross the threshold of a lying-in chamber who is not thoroughly conversant with the remedies for flooding." While some hæmorrhages are unavoidable, the large number can be prevented if the physician in attendance will remember that the patient immediately under his care is liable to have a post-partum hæmorrhage, and he may be required to use emergency means to prevent it.

Causes.—The large majority of hæmorrhages are caused by deficient uterine contraction, but there are other less frequent causes which are equally important, such as degeneration, retained portions of the placenta, lacerations of the vaginal tract or of the cervix, tumors which have become lacerated, and those who have flooded in previous labors are disposed to a recurrence of that trouble.

Symptoms.—In addition to the blood flow, the attendant may find a soft and flabby uterus above the pubes instead of the hard contractive ball naturally expected. There may be no outward flow of blood, but a "concealed" hæmorrhage may be filling up the enlarged cavity of the weak and flaccid womb. The usual symptoms accompanying hæmorrhages from any cause, as pallor; feeble, frequent, thready pulse; restlessness; dyspnœa; thirst; desire for air; and, as the hæmorrhage continues, syncope and death.

Treatment.—The patient must be kept in a dependent position, the head lowered and the feet raised. It is dangerous to elevate the head until all tendency to syncope has passed.

Hæmorrhages from laceration are best controlled by ligature or suture. Kocks advises that when the hæmorrhage comes from degenerated vessels in the site of the placenta, the uterus be inverted as soon as possible, and an elastic ligature applied about the cervix, using, in addition, a tampon made of iodoform gauze. After six hours the tampon and ligature should be removed and the womb replaced.

If the cause be the retention of the placenta, whole or in part, or from the formation of large clots, the cavity should be quickly cleared and contraction urged.

If the placenta has not been removed, grasp the cord, and while making gentle traction on that, with the disengaged hand press into the abdominal cavity between the umbilicus and fundus, making firm pressure downward, and failing to remove the placenta in this manner, while continuing the pressure pass the hand directly into the cavity of the uterus, and quickly and carefully separate adhesions and forcibly remove the cause.

In making pressure on the womb, the physician should always do so with care. A gentle kneading with firm pressure, done in a careful manner, can do no harm, but decided injury may result from roughly squeezing and pushing at the womb, to say nothing of the danger of injury to the ovaries.

When the hæmorrhage follows the removal of the placenta, and is due to atony of the uterus, the treatment must be prompt. A life is in the hands of the accoucheur.

This inertia of the womb may and frequently does follow protracted labor, or the walls may be partially paralyzed by previous over-distension, due to amniotic dropsy, plural pregnancy, or kindred conditions. Too rapid labor, injudicious haste in artificial delivery may be causes, or the uterine walls may be deficient in development or mal-formed, or the flaccid uterine muscles may be due to constitutional weakness.

Proper medicine should be promptly and judiciously administered internally or hypodermically, and such local treatment adopted as will best aid in re-establishing a natural state.

Firm pressure on the uterus, with gentle kneading, should be constantly kept up. Injections of water, at a temperature of 110° to 120° Fahr., should be promptly used, and unless re-

lief is speedily had, follow the hot injection with one of ice-water.

It is highly important to remember that an injection of water moderately warm will tend to increase the hæmorrhage, while if the temperature be too high it may cause a temporary paralysis of the uterine walls. It is claimed that the best mode of using the douche is to inject with the hot water and follow with the ice-water. The advantages claimed are that the styptic action of the hot water is due not only to the swelling of the tissue which it causes, but also to a certain degree of muscular contraction in the uterine walls. The swelling of the tissue is not sufficient in itself to arrest the hæmorrhage, and when the cold douche follows strong contractions of the uterine muscles are excited, while the œdematous swelling caused by the hot water cannot be so rapidly overcome, and we have the two conditions produced which are most favorable in arresting the hæmorrhage. In all cases where the hot or cold douche fails to check the flooding, the use of the opposite is at once suggested.

A piece of ice may be passed into the cavity of the womb, or a lemon cut in half passed in and the juice squeezed out in the cavity.

The most frightful hæmorrhage, with one exception, which has come under my care was checked by the use of turpentine. While passing the house of the patient I was hurriedly called in and found rivers of blood. The woman, bed, floor and midwife were covered with blood. I had neither medical or surgical case, the woman was miserably poor, and the house was barren of ordinary appliances. Feeling that I had no time to hunt up the history of the patient, or to look for symptoms on which to prescribe a drug, I did recognize the alarming fact that something must be done and that something quickly. Calling for cold water with which to dash the abdomen, I passed my hand into the uterus and found it contained neither placenta nor clots. Turning to get the water, I noticed on a table a bottle of spirits of turpentine. Visions of the cut fingers and stumped toes of earlier days, when this was the universal remedy, came up, and, taking my handkerchief, I saturated it with the turpentine, passed it into the womb, and thoroughly swabbed the walls. The effect was almost magical. The

hæmorrhage quickly stopped, and there was no recurrence. The woman was greatly depleted and made a slow but good recovery. China was the remedy administered after the flow ceased.

Vinegar has frequently proven efficacious in controlling uterine hæmorrhages. Dr. Penrose claims that he has used it with invariable success. His rule is to saturate a rag, and, carrying it into the cavity of the uterus, squeeze out the vinegar. The advantages claimed for it are: 1. It can be readily obtained. 2. It can be readily applied, and without special apparatus. 3. It always cures the hæmorrhage, or has never failed in his hands. 4. It is sufficiently irritating to excite the most sluggish uterus to contraction, and yet not so irritating as to be subsequently injurious. 5. It is an admirable antiseptic. 6. It acts on the lining membrane of the uterus as an astringent.

Vinegar administered internally will often act quickly in checking a hæmorrhage without its use locally. It should be given in doses of from a tablespoonful to a wineglassful, and repeated in fifteen minutes. It acts more quickly than ergot. I first used it in October, 1889. The patient was a primipara, seventeen years old, of a highly nervous temperament. Two hours after the end of a long labor violent hæmorrhage came on. Having no ergot I gave two tablespoonfuls of vinegar, and used it locally with a syringe. The hæmorrhage was controlled quickly, and there was no return of it. Caulophyllum was administered in addition.

My attention had been forcibly called to the action of vinegar a month previous by its action in checking the menses; I found the patient suffering from a general inflammatory condition of the viscera. Temperature 105 $\frac{4}{10}$° F.: pulse, 120; face flushed; stupid; bowels greatly swollen and tympanitic, and occasional vomiting of matter mixed with blood. The nurse informed me that the girl had been sick five days, and that the trouble was caused by a suppression of the menses. After her recovery I learned that she had always flowed very freely on the first two days of her menstrual period, and that she had used vinegar to check the flow on a number of occasions, but having on hand a picnic engagement, and desiring its action to be certain, she had drank a teacupful. Since that time I have used it frequently where there seemed to be

atony of the uterus. I never attend an obstetrical case without ergot, but I have used it once only in two years.

Ergot is used more frequently than any other one remedy. When used it should be given by the mouth and injected hypodermically about the thighs. It is usually reliable, but does not act quickly enough when given by the mouth alone. It is for some reasons objectionable; the contractions produced by it are unlike the natural contractions of the womb. It causes in many cases after-pains, and it is claimed by some that it retards involution.

Mistletoe is highly recommended by Drs. R. Lee Payne, Long, Todd, and others; they especially recommend it in that class of cases "in which the loss of blood has been extreme, and the nervous shock so great, that we dare not use ergot lest paralysis of the heart result." They claim it can be used with more confidence than ergot. Some of its special symptoms are violent contractive, labor-like pains; tearing, shooting pains from above downward; pains running downward into the thighs. The hæmorrhage is peculiar in that, while it is continuous, it is at one time in a stream and at another in clots.

Other special remedies frequently used in post-partum hæmorrhages are aconite, apis, belladonna, calcarea carbonica, caulophyllum, china, crocus, ferrum, hamamelis, ipecacuanha, sabina, secale, etc.

Electricity is highly recommended and is without doubt of great benefit. Dr. George W. Winterburn depends largely on its administration, and a case is reported of a primipara, twenty-three years of age, with whom ergot internally and a douche of hot water, followed by vinegar, failed to check the hæmorrhage, when it responded promptly to the use of the battery, the positive pole being in the patient's hand, with the physician holding the negative pole in his left hand, while with his right he grasped the uterus through the abdominal walls.

Compression of the abdominal aorta has been employed in extreme cases as a temporary measure, and with good results.

A vaginal tampon should never be used. By preventing the escape of the blood, the uncontracted womb would be filled and its cavity become larger instead of smaller. It has been recom-

mended that the entire cavity of the womb be packed with iodoform gauze. Several severe cases have been quoted where the packing of the uterus proves successful after other methods have failed. The danger would seem to be the risk of infection.

Care should be taken that the bladder and rectum are not overdistended, as either may have a tendency to keep up the uterine atony.

After hæmorrhage, it may be necessary to resort to measures to prevent fatal syncope, and, in addition to the indicated remedy, stimulants are clearly indicated, brandy being preferable. Give nourishment promptly in the form of strong beef extracts, milk, etc. In extreme cases the legs and arms may be bandaged or raised to impel the blood to the brain, and thus aid in preventing a fatal termination until stimulants have time to act. There should be free ventilation. It is of the utmost importance that the physician should be able to act without excitement, quickly, and intelligently, and the calmness and courage necessary to successfully meet this fearful complication of labor can only come from a thorough knowledge of all the means necessary to control it. A physician should never go to a lying-in chamber without having with him emergency necessities. It is criminal carelessness to trust the life of any patient to chance or to professional neglect.

Perfect cleanliness and all antiseptic precautions are necessary. Material appliances, and quiet, cheerfulness, patience, and a realization by the professional attendant that just then and just there he is to give essential aid in ushering into this world a new life and to save the one from which it comes, are moral agencies which tend, in a large degree, to make the doctor master of this situation.

REMEDIES IN LABOR.

JOHN L. FERSON, M.D., PITTSBURGH.

I ONLY aim in this paper to present the indications of remedies frequently called for during labor, and will present nothing new, because I have pursued no original researches, and have only had access to the literature with which all of you are familiar. I be-

lieve that a careful study of Homœopathic therapeutics on any subject, no difference how often the same ground has been gone over before, cannot fail to profit the student. The discussion and criticism which this paper is designed to call forth, may develop much of profit. I did try to find something new to present to you, and searched diligently, page by page, through six volumes of a journal, the title of which proclaims its chief aim in life to be the dissemination of knowledge which the *Homœopathic* physician can use in obstetrical practice. I found very little of Homœopathic therapeutics, but much in the way of clippings from Allopathic journals, and it is a great pity it is so.

Aconite is indicated in labor when the pains are violent and frequent, and the patient feels as if they could not be borne. She is very restless; is in an anxious state of mind, and apprehensive; fears she will die, and complains that she cannot get her breath. The body is covered with hot sweat, and the vagina and cervix are hot, dry, and tender, and the os is, or may be, rigid.

These symptoms form a striking and unique picture, which is not likely to become confused with any other.

Belladonna, too, has violent labor-pains. They come suddenly, are usually short, and disappear as suddenly as they came. Labor, as a consequence, is slow and tedious. There may be present a spasmodic contraction of the os, with the cervix in the same condition we find present under aconite—hot, dry, and tender. The face and eyeballs are red, and there is a throbbing headache. *Belladonna* may be indicated also in a condition quite opposite to the above, with the pains infrequent, weak, and ineffective, or ceasing altogether, with only periodical slight pressure on sacrum, this inertia placing it in relationship to caulophyllum., gossypium, natrum muriaticum, nux, and secale.

The first picture is the more characteristic.

Pulsatilla.—Pains are spasmodic and irregular, and often cause fainting. Feels as if suffocating; must have doors and windows open to get enough breath. On the other hand, pains may be slow, weak, and ineffectual. In either case, as an aid in the selection of the drug, there is present the mild, tearful disposition which we all know.

The suffocative attacks, with need for open windows and doors

to supply fresh air, are very important, having been frequently verified.

Nux Vomica.—Pains too violent, spasmodic, worse in the back, passing off down to buttocks and thighs; desire to defecate or urinate with each pain; patient constipated; fainting with every pain. *Nux* may be indicated, also, according to Conant, when the above symptoms are present in tetanic rigidity of the os. Again, there may be inertia of the uterus, the pains nearly or entirely ceasing; in which case the previous symptoms, or the temperament of the patient, would have to decide the choice.

Caulophyllum Thal.—Pains spasmodic, intermittent, short, and irregular; pains erratic, flying about from place to place; severe, but cause no expulsive effort. The caulophyllum patient is of nervous temperament; one to whom pain seems intolerable; and these pains, continued without advancing labor, wear her out, and she is almost exhausted. The pains are severe enough apparently, but, in fact, they accompany a uterine inertia. The pains may be severe as above, and progress retarded by a rigid os, with a sensation as of needles pricking the cervix; or again, the pains may be weak, passing off with a shiver, causing much distress.

Cimicifuga.—Pains so severe that patient cries out in agony, and are nearly or quite continuous. There are fainting fits from the severity of the pains, as with nux and pulsatilla. Pains fly across abdomen from side to side (right to left, lycopodium; left to right, ipecuanha).

The continuous character of the pains is in contrast with other remedies, and will serve to distinguish it where the fainting attacks might suggest nux or pulsatilla.

Gelsemium.—Rigors or nervous chills in first stage of labor, for which cimicifuga is also indicated. Labor is delayed by rigid os, which lacks the heat, dryness and tenderness of aconite and belladonna, and the needle-like pains in the cervix, of caulophyllum.

The pains, according to Guernsey's *Obstetrics*, are cutting in character; begin in the abdomen and pass backward and upward. Hering says: "Pains seem to go from before backward, and uterus seems to go upward." Both were probably describing the same sensations.

In an article in the *Hahnemannian Monthly*, vol. xv., page 19, Dr. J. C. Guernsey details a case of labor, in which he emphasizes what he regards as a characteristic of gelsemium in labor. " Pains all in the back, and run up the back, accomplishing no good. ' With rigid os the pains may leave the womb and fly all over the abdomen. Farrington, on page 164 of *Clinical Materia Medica*, advises the use of gelsemium when there is a complete atony of the uterus; the body of the uterus does not contract at all; the neck is soft as putty; flabby; the bag of waters bulging from the os, and there being no attempt at expulsion.

Secale is indicated where the pains are too feeble, far apart, or ceasing; with fainting fits. This is quite in contrast with cimicifuga, nux, and pulsatilla, with which the fainting fits accompany severe pains. With secale the fainting is probably due to a debilitated conditon. The patient is weak, thin, scrawny and cachectic, with shrivelled, dry, harsh skin; or one who is debilitated from venous hæmorrhage.

The uterus is as flabby, Farrington says, as if it were mucous membrane only, and not a muscular organ; which recalls what he says about gelsemium.

Ignatia is useful when the pains are too weak, or ceasing, with rigid os.

There are hysterical symptoms which are sometimes so severe as to seem to threaten convulsions. Breathing is embarrassed; in order to breathe at all one must breathe deeply; sighing breathing; sadness.

Natrum muriaticum, in labor, has sadness, similar to ignatia, with forebodings; the pains being very feeble.

Chamomilla.—Pains which begin in the back and pass off down the inside of the thighs, and are tearing in character, spasmodic, and distressing. The patient is intolerant of pain, as under aconite and caulophyllum, and is very nervous. She is spiteful and cross; cries out sharply, or shrieks; she cannot answer any question with civility; is pleased with nothing; os may be rigid.

The pains of *kali carbonicum* also begin in the back and pass off down the buttocks. The pains are sharp, cutting, stitching, in character.

Cocculus.—Pains are of a spasmodic, irregular and paralytic character. There will be one hard pain and after an interval several light ones. Lower limbs feel numb and paralyzed.

The characteristic symptom of *ipecacuanha* is the presence of persistent nausea. The pains extend across the addomen from left to right.

Another remedy having nausea attending labor is *lobelia inf.*, but it is not so persistent as with ipecacuanha. Different from ipecacuanha, it has violent dyspnœa accompanying the pains, which renders them useless. The os is thick and leathery.

Lycopodium.—Pains fly across abdomen, which reminds one of cimicifuga; with the latter they begin on either side; with lycopodium they begin on the right side and extend to the left, just opposite to ipecacuanha.

During the pain the patient must keep in motion, with weeping and lamentation. The pains run upward, like gelsemium, but point of origin is not given.

In the foregoing, chamomilla, gelsemium, kali carbonicum and nux have pains worse in the back; with gelsemium the pains go up the back; the pains of chamomilla, kali carbonicum and nux all go down the thighs; with chamomilla the pains descend inside the thighs, and are tearing in character; with kali carbonicum, pains pass down the buttocks and are sharp, cutting, and stitching; with lycopodium the pains go upward, as with gelsemium, but do not begin in the back.

Caulophyllum and gelsemium have erratic, flying pains.

Fainting with the pains occurs under cimicifuga, nux, and pulsatilla, while with secale fainting occurs without pains.

With pulsatilla, ignatia, aconite and lobelia, there is difficulty of breathing; with pulsatilla, patient must have doors and windows open, in order to get air. With ignatia, frequent deep sighs; must breathe deeply. Aconite feels as if she could not get her breath. Lobelia has violent dyspnœa with the pains.

Ignatia and natrum muriaticum are both accompanied by sadness.

Ipecacuanha and lobelia both have nausea; with ipecacuanha, more persistent than with lobelia.

Cocculus is accompanied by the paralytic feeling in the lower extremities.

For weak pains, belladonna, nux, secale, gelsemium, caulophyllum, ignatia, natrum muriaticum, pulsatilla.

For violent pains, aconite, nux, belladonna, cimicifuga, caulophyllum.

For rigid os, aconite, nux, belladonna, gelsemium, chamomilla, lobelia.

Pains short and severe, belladonna, caulophyllum, ignatia.

Cessation of pains, gelsemium, nux, secale, ignatia.

Gossypium, *viscum album*, and *leotine* are all spoken of highly as useful remedies where there is a total lack of symptoms, or where it is desired to give material doses. Several articles have appeared in the *Obstetric Journal* (Homœopathic) within the last few years on the value of *viscum album*. It is claimed for it that it produces strong uterine contractions of intermittent character (not tonic, as with secale), allowing between pains natural regular intervals of rest, and that it may be used in any stage of labor in either primipara or multipara.

Dose, fifteen to sixty drops every twenty minutes, of the tincture.

Leotine, the alkaloid of caulophyllum, is mentioned in the *Hahnemannian Monthly*, vol. 23, page 540. It is about eight times as active as caulophyllum, and has been found to equal ergot in causing expulsive contractions of the uterus, but without pain. Whether the contractions are intermittent is not stated, but judging from the action of caulophyllum it is to be supposed they are.

Guernsey's *Obstetrics* mentions *gossypium* as of use in cases of lingering, almost painless labor, where uterine contractions are entirely inefficient; negative rather than positive symptoms.

BUREAU OF GYNÆCOLOGY.

Clinical Cases, by Millie J. Chapman, M.D.
A Clinical Case, by Pearl Starr, M.D.
Mental Suggestions, by P. A. Bier, M.D.
The Sympathy or Relation Between Uterine and Rectal Diseases, by Sarah J. Coe, M.D.
Typical Cases of Ovarian Cystomata Successfully Treated by Abdominal Section, by Theo. J. Gramm, M.D.

CLINICAL CASES.

MILLIE J. CHAPMAN, M.D., PITTSBURGH.

THERE are fashions in medicine as well as in millinery. Some form of treatment has a popular run until superseded by another, which, in due time, is abandoned. As yet, there have appeared no "fall styles" in treating diseases of women. The morbid conditions exist and are constantly demanding attention, the practitioner adopting one of the various methods as his fitness, intelligence, or experience influence him to choose. Withal, there is a tendency toward a reaction from the practice of frequent laparotomies or ovariotomies for the morbid conditions of the ovaries, tubes, or uterus, and a growing inclination to doubt the benefit of repairing a lacerated cervix. While McDowell and his successors have been able to prolong many useful lives, there is no doubt others have been sacrificed to the enthusiasm of the operator. Again, it has been found later that some other tissue was the irritating element for which these organs have been so boldly attacked.

Gynæcology is not always a branch of general surgery. It is sometimes difficult to decide whether the treatment should be surgical or medical. All such cases are safely treated if first given the benefit of the action of remedies. The effect upon the nervous

system is such that no woman should undergo either of the many operations unless there is reasonable hope of greater benefit resulting than can be realized from other measures.

Many cases under suitable medication, though not wholly cured, live longer, are more comfortable, and, hence, more useful than if otherwise treated. We know that Homœopathy does more to make the sick woman well than any other agent, yet we do not ignore the necessity of measures to secure cleanliness, surgical dressings, etc.

In February, 1888, Mrs. T. applied to me for treatment. She was suffering from neuralgia, generally located about the head and face, but at times attacking almost every organ. I saw her a few times. There was no seeming improvement, and she was persuaded to consult a surgeon, who warranted a cure by amputation of a lacerated cervix of the uterus. I knew the laceration existed, but as she had passed the menopause, and no tenderness or local irritation was found, I did not consider attention there necessary.

The operation was performed and the recovery slow. The shock to her already shattered nerves was very great. No sooner was she about than the old suffering returned with all its violence and frequency. The surgeon was appealed to for an explanation of the failure. He replied: "Oh, yes, she will have neuralgia, but I cured her of the laceration." His boldness and courage induced him to assume the responsibility of an important effort, and added one to his long list of similar procedures. The patient paid a large fee, had weeks of uncertainty between life and death, and gained nothing. Then the original malady was suppressed by narcotics, until she is a fit subject for the "Keely Institute" or other agents promising relief from the morphia habit.

Patient No. 2, appearing the same day as the former, had consulted a surgeon first. His manner and requirements were discouraging, and caused her to try what others promised before accepting his services.

Here I found an inflamed, sensitive ovary, cervix lacerated, edges everted, eroded, and a constant, profuse, acrid, mucous secretion, irritating vagina and perinæum. As she was only about thirty, I advised her to expect the treatment to be a preparation for

repair of the laceration, as more hopeful of removing her headache and other pains, as well as insuring more probability of a safe delivery should she again become pregnant. She arranged to see me once a week for a time, and then enter the hospital for such treatment as was found necessary.

From the first her improvement was such that her visits did not increase in frequency, and the hospital was never benefited by a desirable patient.

The cervix was cleansed and protected from friction against the vaginal walls, when walking, by a wool tampon and some antiseptic dressing, usually boroglyceride cerate, applied when I saw her, and retained while it remained in position to be comfortable. Remedies were prescribed as closely as I could from the symptoms reported at each visit. Belladonna, hepar sulphur, calcarea phosphorica, caulophyllum, and arsenicum album were the principal medicines given. She was under my care eight months. The normal circulation was so nearly restored that the erosion was gone, and there was no appearance of congestion. The reflex symptoms were removed.

A recent report was the repetition of many since my last prescription, viz.: "I am a well woman, busy with housekeeping and my family." As intimated in the beginning, this is no *new* story, nor considered marvellous treatment, but a review of an ordinary average case, more frequently met with than those demanding capital operations. The suffering of a wife and mother, induced by the accidents of labor, was removed without incurring risk of life nor one day of enforced absence from usual duties.

DISCUSSION.

Dr. Z. T. Miller called to mind two cases which had come under his observation. In the one there were present all the symptoms which indicate involvement of the ovaries, and to effect a cure removal of these bodies was resolved upon and effected. So far as the relief of the symptoms was concerned, the result was a complete failure, though the woman had no ovaries. In another case, too, presenting the same train of symptoms, similar treatment was adopted and similar results obtained. In other cases, where he adopted a method of treatment similar to that suggested by Dr.

Chapman, he cured his cases. He called to mind a case of indurated vagina, with a badly lacerated cervix, covered with excrescences, in which he got good action from kreosote.

Dr. Schmucker thought that the inference drawn from the paper was entirely too broad. He expressed himself as being decidedly in favor of a repair of cervical lacerations. Where reflex nervous symptoms are due to the presence of a cicatrix, that irritating cause must be entirely removed. He recalled a case of a woman who was a complete wreck, both mentally and physically. Though apparently a healthy woman, she spent the greater part of her time in bed. Upon careful examination, the cervix was found to be lacerated badly. Careful operation was made, the part healing kindly. She was kept quiet for three or four weeks, and the result was all that could be desired.

Dr. J. S. Skeels expressed himself as being in favor of the principles laid down by the author of the paper. He would discard the operation on the belief that when we get rid of the diseased condition of the organ itself, which can be done by therapeutic measures, the patient will be entirely well.

Dr. Holcombe told of a case which came under his observation one year ago. The lady was suffering from symptoms which seemed to be caused by the presence of a cervical laceration. The condition was so bad that she was hourly expected to die. Some time before he saw the case an attempt had been made to repair the laceration, and immediately following this developed the condition described above. The case proved to be one of pelvic abscess, which discharged, and the patient recovered. It is wrong to unqualifiedly condemn operations; there are times when they are a necessity, and great benefit is derived from them.

Dr. Sanders endorsed Dr. Schmucker's ideas. He had seen very many operations for ovariotomy, for the removal of the appendices, and for amputation of lacerated cervices which had given excellent results. These cases, however, should, by all means, first exhaust all medical and topical resources.

Dr. Chapman said that in her attempt to abbreviate the paper she felt that she had been possibly indefinite, and, as a consequence, had been misunderstood. Her idea was to call attention to the fact that, in this class of cases, local treatment was of much benefit.

Very many cases might be entirely cured by the use of medical treatment, both internally and locally. She does not, of course, condemn surgery altogether. She recalled a case, that of a lady, who came to her and asked for treatment for erosion of the cervix. She told the doctor that her former physician had said that she had erosion, and, of course, must have treatment for it. Dr. Chapman wished to impress upon the minds of her hearers that they must not encourage a morbid mental condition by enlarging on the evil effects of the presence of the laceration, erosion, or whatever it might be. Similarly, too, a patient must not be discouraged by being told that surgical interference must be a necessity. I, at times, advocate operations. In my second case I supposed that surgical interference would be necessary, but the improvement was so rapid that I did not resort to it. I yield to no one in my loyalty to the surgeons, but I do believe that many a case is operated upon when that operation is not necessary. The cure could be accomplished much more readily and safely by local and medical treatment. I believe, with Dr. Miller, that many a woman whose cervix is lacerated is, to-day, walking about the streets, she not having the remotest idea of her condition.

Dr. Skeels reiterated his expressed opinion that operations are not necessary; that all the benefit which may be given can be derived from local and internal treatment with Homœopathic remedies.

A CLINICAL CASE.

PEARL STARR, M.D., BELLEVUE.

Mrs. B., aged forty-six; normal weight, one hundred and sixty pounds; light hair and blue eyes; who was a resident of Pittsburgh, and, I think, born and reared there. She was an intelligent woman, being a graduate of the Pittsburgh High School.

The patient came under my care August 1, 1890. She had been married two years previously, and had removed to Colorado. After a brief residence there, she became enervated (a condition,

she told me, common to the women of that section of the country, the climate being very dry. Two and sometimes three months elapse without rain). Accompanying this enervation she had suppression of menstruation. She consulted a physician, who gave her a prescription. After the second or third dose of the medicine prescribed, she was unable to leave her bed. The medicine was discontinued, and in a few days she was around again, but did not gain strength, and felt she was growing worse, and she determined to return to Pittsburgh.

The old family physician, Dr. L., was summoned. After examination, he pronounced the case one of pregnancy. Not being a specialist, he called in three of the leading specialists of the city (Old School). After a thorough examination they pronounced the case one of tumor (as far as the patient knew, the kind of tumor was not diagnosed). From the weakened condition of the patient, and the strenuous opposition of Dr. L., who insisted that no operation should take place until they were certain that it was not a case of pregnancy, it was decided to await developments. A little later, an Allegheny specialist was called to examine the case. This was during August, 1889. He said: "One thing is certain; that is an empty uterus." Sensations, which Dr. L. claimed were "motions," he said were due to gases in the intestines. The babe was born in December, and it was an instrumental delivery in consequence of the weakness of the patient. The child was perfectly developed and medium in size.

After recovery, another examination was made by the same physicians. They said the tumor at that time was the size of an orange.

There was continuous pain in the tumor, and paroxysms that became occasionally so severe that suppositories of morphine and belladonna were employed. These paroxysms increasing in frequency and severity, the morphine was increased to $\frac{6}{8}$ grain. From the latter part of May, 1890, until the 1st of August, the patient was not able to leave her bed, excepting as she was lifted to an invalid chair and wheeled to the window.

The tumor was pronounced malignant, and her friends notified that she might die at any time; there was no possible hope of recovery.

There was continuous pain, and the severe paroxysms would occur, sometimes two or three in a day, then one, or perhaps two, days might elapse without one. These paroxysms would be followed by vomiting (could take no food), constipation, suppression of the urine, and night-sweats. It was necessary to change the clothing three times almost every night.

On the 1st of August, 1890, I was called to take charge of the case. The previous night she had a very severe paroxysm. It was three hours before the morphine would take effect. The morning I saw her she was much exhausted; she had slept but little for some time (had always been a light sleeper).

The walls of the abdomen were relaxed, and the tumor could be clearly outlined. It lay to the front and a little above the crest of the right ileum, and was fully as large as the head of a child at full term and as firm. The tumor and walls of the abdomen, from the kidney to the umbilicus, were very sensitive; she could scarcely permit me to examine her. There was a sulcus across the right nates in which the hand, on its side, could be laid, having the appearance of something drawing on the vessels and nerves issuing from the great sciatic notch. The measurement of the abdomen over the crests of the iliæ was forty-one inches. I made no vaginal examination because of the sensitive condition and the opposition of the patient. She had given up all hope, and relief from the severe paroxysms of pain was all she desired until the end should come. Her countenance had a wild, distressed appearance, and her flesh a clear, straw color; she was much emaciated, and would have weighed little, if any, over a hundred pounds.

The urine in twenty-four hours did not exceed a half pint, and, after standing ten or twelve hours, was fully one-third sediment, mucus, pus, and blood. The watery portion was almost the color of fresh blood.

I put the patient on arsenicum album 6x, once in two hours. One week passed with but one paroxysm in which it was necessary to resort to morphine. This was the last time the morphine was used. The arsenicum was continued in the same manner. The appetite improved, the urine increased, the constipation was relieved. (This latter condition I accredited to the discontinuance

of the morphine, although the patient had always been of a constipated habit.) The tenderness decreased. During the second week the patient complained of nausea. The arsenicum was given four times per day, and the nausea then disappeared.

In the third week, ergot was given in alternation with the arsenicum. At this period she astonished her friends by coming in the back door, having risen, dressed, gone from the front door, down four or five steps, and around the house, her only assistance being a child not yet three years old. No aggravation followed.

The tenderness at this time was mostly confined to the tumor. During the fourth week she menstruated; the pain and tenderness increased during this period; as soon as that was over they again decreased. She was now able to go around the house to and from the front gate, a distance of about one hundred feet.

At the end of the second month she walked a distance equal to three squares in the city, to the station, took the train for Allegheny, walked from Allegheny depot to Boggs & Buhl's and back, up the hill from the home station. The next day there was increased tenderness in the tumor and abdominal walls, which passed off after a few days.

Menstruation becoming too frequent, the ergot was discontinued, and there was no farther trouble in that direction. The night-sweats had ceased; the urine became normal; there was but slight tenderness in the tumor, and none in the abdominal walls. The tumor had shrunken and sunk down into the abdomen; sleep and appetite improved; she gained in weight and strength; the flesh assumed a healthy appearance.

The nurse was discharged and the lady took care of her own babe, and could go up and down stairs and carry her child, eleven months old. Before Christmas she was able to come from and go to the city two and three times a week. The walls of the abdomen became tense and the sulcus filled. Nothing could be ascertained by measurement; as the tumor shrunk and sunk into the abdomen, she gained flesh. The mechanical inconvenience disappeared as the tenderness lessened, and the tumor changed position.

When she commenced to get around, the abdominal supporter was used, but, after Christmas, this was abandoned. In the first

part of April she went to Missouri, a continuous journey of thirty-six hours, and had all the care of her child. No aggravation followed.

Word, a few days since, says she feels perfectly well; she is living on a farm of three hundred acres; she does all her own housework, including washing and ironing, and takes all the care of her child.

This case was under treatment about six months. She received no other remedies but the two named, excepting once, when she had taken a severe cold, for which she was given nux vomica. As soon as relieved the other remedies were resumed.

The case was diagnosed ovarian.

From her earliest menstrual life she had suffered from pain in her right side during that period. The aggravation of the pain and tenderness in the tumor came during that period.

The position of the tumor seemed to make it reasonable that it was in some way attached to the vessels and nerves issuing from the great sciatic notch, and caused the sulcus, which filled as the traction lessened. The pain would follow the course of the sciatic nerve, as well as extend over and through the abdomen.

DISCUSSION.

Dr. Miller said he had never cured a case like that, but he had had a similar case where the symptoms had been greatly relieved, but the tumor still remains. It seems to be attached to the liver, and while it is still there, it is not any larger than it was. In prescribing for this case, he took into consideration the family history. All the members were sickly, weak, and there were suspicions of hereditary trouble. He gave natrum sulphuricum 2c, and certainly helped the condition.

CASES OF MENTAL SUGGESTION.

P. A. BIER, M.D., PITTSBURGH.

HAVING, after a careful review of text-books, decided that I could not satisfactorily present a paper upon old-time subjects, I concluded to present a subject which bears a closer relationship to diagnosis and treatment than many of my materialistic friends in the practice of medicine will at first admit; and I anticipate that many of you will listen with an incredulous smile; but, withal, facts are facts, and I am convinced that too little attention has been paid to the psychological mode of treatment, and that there is a psychic sense which can and needs to be developed. "We live in this life in an ambient intellectual centre, which entertains between human beings and things a necessary and perpetual solidarity; every brain is a ganglion, a station of universal neurological telegraphy in constant rapport with the central and other stations by the vibrations of thought." This assertion is more fully explained in Bjornstorm's work, entitled *Hypnotism*, page 71. Under the heading, "Mental Suggestion," he says: "In our description of the many effects of hypnotism, and of the wide influence of suggestion, we have arrived at phenomena more and more wonderful and difficult to understand. Until now, however, we have been somewhat able to follow the natural ways suggestion chooses for imparting the ideas and will of one man to the brain of another. We now come to a group of phenomena in which the ordinary mental routes and stages in the journey of ideas from one brain to another is passed with one leap. We refer to the effects of the so-called mental suggestion, which might be defined as transmission of thought, and which, from a certain point of view, embraces mind-reading. For by "suggestion mentale" the French mean the operation by which thought, sensation, will, or any physical force affects the brain of another directly, in what may be called an immaterial manner, without manifesting itself further by anything perceptible to the external senses, either by words, looks, gesture, posture, etc. It is with a certain hesitation that we enter

upon this, as yet, mysterious subject; but it should be said of this, and equally of magnetism and hypnotism generally, that their abuse by the charlatan and the knave must not obscure the real facts which a conscientious scientific investigation has brought to light; and even though the explanation may be difficult, it is useless to deny and conceal facts of whose reality many experienced scientists and other sensible persons of the most civilized countries are already convinced."

To be brief, I will relate my first experience, and then allow you to decide whether it is mere fancy and coincidence, or that there is a psychic force and law controlling the same.

In the year 1880 I was called upon to attend Joseph S., æt. 5, scrofulous, attacked with scarlet fever, a hopeless case from the beginning, but there was one singular feature throughout. Up to the time of death he was delirious constantly, except when I entered the room; he would answer every question intelligently, but would lapse into delirium as soon as I departed. Being near by, I would call four and five times a day. The night he died I had retired early, and in my sleep was poring over materia medica, to discover whether I had prescribed the indicated remedy, when I was arrested by a voice addressing me: "It is no use; Joe is dead." I glanced at a clock on the mantel and noticed that it was 10 minutes after 12. I awoke and failed to gain much sleep after that; arose early, called upon the family, was met at the door by an elder brother who informed me of his brother's death, and I in turn to his surprise informed him that I knew of it and gave him the time, which corresponded exactly. His mother made the remark that I heard in my sleep, and he had glanced at the time when he died. This case set me to thinking, and I decided to experiment with sensitives. The opportunity soon came, in a highly sensitive and intelligent woman, who had been suffering with anteversion and ulceration of os, and had been treated heroically with caustic, etc. I discovered, by placing myself in a negative condition and *en rapport* while she related symptoms, that frequently her thoughts were transmitted before she uttered them. When I prescribed I became positive, and the remedies acted with surprising effect. In a few weeks she was perfectly well. During treatment she was aware that I had an influence over her which she could not un-

derstand, and frequently inquired what it was, but I gave no satisfaction to her inquiries until compelled by an experiment, which was as follows: Coming home about one o'clock in the morning from seeing another patient, I decided on an experiment. Picking up a copy of Longfellow's Poems which I had previously been reading, I turned to the "Village Blacksmith," concentrated my mind upon my patient and informed her that I intended to read. In a distinct tone of voice I read the poem, closed the book and retired. In the morning I found a note slipped under the door requesting me to call immediately after office hours. I did so, and was confronted by my patient with the information that no one was sick, but she wanted to know what influence I exercised over her and that I must inform her before leaving the house. I plead ignorance, and asked why she would insist upon my giving information upon a subject that I was not acquainted with, or cognizant of. She replied: "Doctor, you do know; you stood by my bedside last night and read 'Longfellow's Village Blacksmith.'" I explained, and she informed me that she would resist my influence, but she has never succeeded. I have often prescribed for trial alcohol in water instead of the indicated remedy for excruciating neuralgia to which she is subject, and it has had a marvellous effect. I have never had any difficulty in prescribing for her, and she has always made quick recovery.

Another case shortly after: A Mrs. T. (mental motive temperament. Always classify temperaments according to the phrenological idea—mental, the nervous; motive, the bilious; vital, the sanguine; lymphatic, diseased temperament) was suffering with ovaritis. I followed the same procedure in giving her symptoms. She made a quick recovery. I treated her at different times for endometritis, pneumonia and other disorders, and she has always responded rapidly. I have frequently prescribed saccharum lactis, and it has had a speedy effect. I have always prescribed low potencies, 3, 6, 12th, and have no doubt that the higher would act as well. Many of the cures attributed to remedies are as much due to a conscious or unconscious influence of the physician which causes a mental stimulus and a consequent physical change. These were my first experiments. I have continued ever since. My relationship to many of my patients is such that at a distance of many

miles, I am aware of an unexpected aggravation of their condition.

Another illustration of this psychic sense. My wife and I had been to the opera, and while in the cars I was in a negative state, when I received an impression that a Mr. S. had called and was anxious for me to see his wife. I had not attended, seen, or heard from them for at least six months. When we arrived at home I found a message for me to call. His wife was suffering intensely with enteralgia.

In conclusion, I desire to state emphatically that there is no departed spirit business about this, and if any of my professional brethren are investigating Spiritualism and expect to diagnose and treat patients as directed by departed mortals, they will soon come to grief.

THE SYMPATHY OR RELATION BETWEEN RECTAL AND UTERINE DISEASES.

SARAH J. COE, M.D., WILKES-BARRE.

It was not so much to present a lengthy paper on this subject that it was chosen, but rather to suggest points for discussion, knowing that benefit comes to the physician by comparing practical experiences.

Whether these conjoined troubles are more numerous of late, or whether my attention has been more particularly called to them in the history of the cases as related by the patients, at least three-fourths of the cases have presented an associated trouble, or sympathetic, if you prefer the term.

Recently, say for a year past, the majority of my cases have been examined per rectum as well as by vagina.

In many cases, especially in girls in their teens, their pelvic troubles, as pain in back, bearing down, difficulty in standing long, tired on slight exertion, have been relieved entirely and immediately, by the simple insertion of the finger through the anus

into the rectum, and carried as high as the sacral promontory, while in the genu-pectoral position.

This procedure has also corrected some cases of dysmenorrhœa, from which I aver there must be a relation or sympathy between an irritable anal sphincter, affecting or throwing into discord the pelvic nervous system, and many times causing much spinal difficulty.

Besides a highly sensitive anus, I have found in these cases usually, some prolapse or sagging of the rectal walls sufficient to produce a dragging from the superior pelvic region, causing the tired sensation when standing long.

The immediate relief experienced, has been by adjusting the parts to their normal anatomical relation. It has been found much easier to accomplish, more permanent, and thus more satisfactory to both patient and physician, to replace while in the genu-pectoral position, the weight of the intestines acting as a force in front, while the finger with its elevating force from the rear puts the rectal walls on the stretch.

At the same time it affords an opportunity to ascertain if the ovaries and uterus are in position, also, if there is any trouble at the junction with the sigmoid flexure.

Restoring the parts to their true anatomical position also relieves the congestion of the pelvic vascular system, putting at rest the inflamed parts, giving them time to recuperate and restore their normal action.

These patients (misses) have not been required to abstain from their usual occupations or pleasures, but have been cautioned when alighting from their horses, carts, or bicycles, to let the weight of body come upon the toes, *never* upon the heels. They have also been advised to break long walks by resting places, avoid straining at stool, avoid tight corsets or pressure from above. When these directions were followed, one rectal treatment, plus the indicated remedy at the time, has served to cure many cases of so-called ovarian trouble.

Perhaps the clearest case of the association of rectal and uterine trouble, similar to those the gynæcologist frequently meets, came under my care while preparing this paper. It had marked reflex troubles with the eyes, stomach, and head.

History of her case as given in the presence of her mother: Commenced to menstruate at thirteen years of age. Had dysmenorrhœa from the first menstruation, now eight years. Latterly the pains were very hard from the waist line down, even to the knees, during the first two days, while at times it would be as though a hand grasped and twisted her in the hypogastrium.

Menses scant, although a robust form. Backaches all the time between the periods. Never free from leucorrhœa. Has constipation with smarting in anus during evacuation, beating, burning, and throbbing after, with an uneasy feeling all through the nates; cannot sit still. Conscious of a pain or fulness most of the time in the region of left ovary. "And then I am so troubled with indigestion; distress in my stomach. Back of head aches so much, or else through my forehead and eyes; eyes feel weak and strained." Nervous? "Yes, and blue all the time, and exert myself to keep cheerful before my friends!"

The relation of this history was interrupted several times with spells of nervous crying. Yet she declared no one should ever touch her for an examination, by rectum, even if she suffered till death.

The next menstrual period brought her to decide differently, from its greater severity, and she allowed an examination per rectum, when an enlarged inflamed, prolapsed ovary was found closely confined in sagging rectal walls, all pressing heavily downward upon a sensitive anal sphincter. The replacing was done in the genu-pectoral position, when she experienced relief at once in the side and rectum. The constipation improved, and many of the reflex symptoms more remote cleared away, and she was once more cheerful.

Take another class of diseases, say the rectal ulcer and fissure of anus, the patient seldom locates the trouble in the right place, but will remark, "I think I have a uterine weakness, and then I am so constipated."

History of the case together with careful examination will reveal the major ailment on the rectal side, causing perhaps a sympathetic leucorrhœa from the vagina, thus deceiving the patient as regards the locality of the ailment.

A very sensitive ovary slightly displaced has often been likened

to inward piles, and the physician sought eagerly for that disturbance. Probably the most common ailment complained of is constipation, when the associated cause is a retroflexed, retroverted or prolapsed uterus, yet they will declare they have no womb trouble.

Again, a highly inflamed uterus, or even a congested one, will simulate or act as an unrecognized cause of constipation, while some of the severest cases of dysmenorrhœa under my notice have been associated with diarrhœa.

From the papers and discussions at our recent Institute, we learned the benefit resulting from orificial surgery in the hands of the specialists.

I will relate one case only as applicable to this paper, yet giving *marked reflexes*—a subject of growing importance which might furnish a paper by itself.

A young woman, in chlorosis, with painful, scant menses, constipation, pain as if pulling downward through both hypogastriums, backache, melancholic, thoroughly discouraged, having been under the care of a physician for one year and a half, was so much relieved by the rupturing of a tough, sensitive, nearly imperforate hymen, that she excaimed at once, "Why, doctor! I feel better already." And the melancholic look seemed to lift from her countenance like a cloud before the rising sun.

Later, the uterine cervix was dilated, and she rapidly regained health.

We need not prolong the paper with remarks upon other pelvic inflammations of the tubes, ligaments, and surrounding tissues with their concomitant symptoms in the rectum. Sufficient has been said to establish the fact that because of the anatomical relation between the rectum and genital organs, one diseased or misplaced, will react upon the others causing symptoms simulating trouble in other and sometimes more remote parts.

Dr. Skeels reported an anomaly in breast development occurring in his practice: In Erie county, Pa., on the first day of August, 1891, a good hearty young lady, married, gave birth to a healthy boy baby. When the nurses put the baby to the breast

there was found a supernumerary number of nipples. The right breast was natural, the left one was double, having two nipples. The left breast was larger than the right one. The proper nipple seemed a little higher up than its fellow-mate on the right side. The supernumerary was two and one-half inches below and a trifle to the left of a perpendicular line. All three nipples yield milk, and baby likes them all.

TYPICAL CASES OF OVARIAN CYSTOMATA SUCCESSFULLY TREATED BY ABDOMINAL SECTION.

THEODORE J. GRAMM, M.D., PHILADELPHIA.

THE cystic tumors of the ovary present many points of interest to the general practitioner, the surgeon, and the pathologist. Being the most frequent new formation affecting the ovary, their occurrence has long been known, and the enormous size to which they sometimes attain has often been the occasion of remark. Historically, it will be remembered, it was for the relief of these tumors that the abdomen was first designedly opened ; and since the advent of antiseptic methods in surgery, they have furnished the most frequent occasion for performing abdominal section.

Surgically, also, they are very susceptible of successful treatment, and, the diagnosis of ovarian cystic disease being determined, it is with considerable assurance that the surgeon undertakes the major operation of their removal.

From a pathological aspect, however, these tumors certainly excite much interest, especially when it is considered that they arise from the whole or a part of a diminutive gland, and ultimately attain a size equal to many volumes of the ovary, and, in some instances, equal or exceed, the weight of the whole body itself. And, moreover, when it is considered that many, indeed most, points in reference to their primary exciting cause, the ultimate tissue-elements from which they spring, and their manner of growth, being as yet the subject of controversy, it will certainly

be admitted that cystic ovarian tumors have much of interest connected with them.

The cases which I have the honor of presenting to you, while being typical examples of one of the most frequent types of cystic tumors, namely, the *cystoma proliferum papillare*, and, while not occasioning astonishment at any mammoth proportion attained, yet present many interesting features, both from a surgical and a pathological aspect.

In both cases an accurate diagnosis was made before operating. They occurred in the practice of my friend, Dr. A. M. Barnes, through whose kindness they came to me.

The first case, that of a woman, American by birth, aged 66 years, a widow for five years, having had no children, and an uncertain history of one miscarriage shortly after marriage. She began to menstruate at thirteen years of age, and ceased at the age of fifty. About the time of the death of her husband, five years ago, she says she had "inflammation of the stomach," concerning which no definite information can be obtained, except that she had great pain in the abdomen, but no diarrhœa.

About four years ago, she first noticed her abdomen enlarging on the right side, and had pains in both ovarian regions. For a long time she has had much oppression in the epigastric region and flatulence; and, lately, has had considerable difficulty in breathing. Her bowels have been inactive for a long time, and even then she would have no movement unless from the action of a cathartic.

When first seen she was in a bad condition, being greatly prostrated, frequently vomiting a watery fluid, which she had been doing for the past five days, her bowels having been moved from the effects of a seidlitz powder taken the previous night. Her tongue was quite glazed and red; she was very restless, and her pulse was 96 and weak.

Her abdomen was considerably enlarged, the greatest prominence being just below the umbilicus, which was displaced upwards, the skin being marked by many *lineæ albicantes*. A distinct tumor could be felt, which seemed to be slightly movable. The measurements were:

Between superior spines of ilium, 43 cm. (15 inches).

Pubes to umbilicus, 23 cm. (9 inches).

Umbilicus to ensiform cartilage, 17 cm. (7 inches).

Circumference over most prominent part, 1 metre (40 inches).

On percussion: abdomen tympanitic in flanks; dull towards anterior abdominal wall, and quite flat over the linea alba. A slight sense of fluctuation could be felt across the abdomen, and also with one finger in the vagina.

Examination *per vaginam* showed the pelvis to be almost completely filled by a somewhat fluctuating tumor, slightly movable on the right side, where also the tumor imparted a greater sense of resistance, as though composed of more solid tissue, and on its surface presented a number of hard nodules. The os uteri was somewhat soft, lay high up, and quite displaced to the left, the sound penetrating 6 cm. ($2\frac{1}{4}$ inches), and pointing toward the crest of the left ilium.

Per rectum, examination revealed the lower bowels to be free, as far as the finger could reach, and the tumor was felt to be anterior to the rectum.

On June 18th, of last year, I operated by abdominal section, being very kindly aided by Drs. Van Lennep and Carl Vischer.

An incision was made in the median line, reaching a firm resisting tumor, having a yellow color, as though containing pus, which, however, being incised and having a trocar inserted, gave exit to a brownish, grumous fluid, in quantity about three quarts.

The cyst was then delivered, was found to be of ovarian origin, and to start from the left side. The pedicle—a rather broad one—was transfixed and tied off with four silk ligatures.

On the right side, and jammed down in the pelvis so that it was moved with difficulty, was another tumor covered by the peritonæum, the broad ligament, the Fallopian tube forming a ridge on its upper surface. This tumor could not be removed until its peritoneal covering containing the tube was stripped backwards, thus partly enucleating the tumor, and permitting its upper surface to be brought up to the incision. Its contents, paler in color and more serous in character, were then drawn off, in quantity somewhat over a pint, and the pedicle tied with two silk ligatures.

The abdomen then presented a most interesting condition. The abdominal walls, necessarily incised to slightly above the umbil-

icus lay in flaccid condition upon the abdominal contents, and, on being slightly drawn aside, permitted an inspection of the pelvic cavity, revealing the fact that the uterus was in a rather exceptional condition. On grasping its fundus through its antero-posterior diameter and drawing it slightly upwards, its upper surface reached considerably above the brim of the pelvis, in appearance being red, congested, flattened from pressure about 3 cm. ($1\frac{1}{4}$ inches) across its widest part and 1 cm. thick, and to the touch being quite soft, resembling therefore in many particulars a piece of small intestine. This condition had evidently been brought about by the left tumor having most likely, very early in its development, become extra pelvic, had drawn the uterus upward on that side; and then the right tumor becoming intra-ligamentous and developing most within the folds of the broad ligament had retained, attached upon its upper surface, the Fallopian tube and acted therefore by pushing upward the right uterine cornu. And, moreover, the right tumor enlarging laterally had displaced the intra-vaginal cervix to the left somewhat, but had deflected the fundus greatly so that at its lower portion the uterus lay in contact with the left pelvic wall and at its upper part by the side of the right tumor, around it and above it and at all parts of its elongated course was subjected to pressure and tension.

The sound, as has been said, passed 6 cm. ($2\frac{1}{4}$ inches) into the cavity, and although no measurements were taken at the time of the operation, I have no hesitation in saying that the uterine cavity measured at least 18 cm. (7 inches) in length.

After cleansing the peritoneal cavity with hot distilled water a small glass drainage-tube was inserted and the incision closed with silk sutures.

The patient rallied well after the operation. Her temperature, taken hourly, fell persistently from 101.4° reaching normal on the evening of the second day. The drainage-tube was left in for 40 hours longer than intended, on account of having been prevented by an obstinate case from seeing the patient, and the stitches were removed on the eighth day.

This patient has made a very good ultimate recovery, following her avocation of obstetric nurse and having recently nursed with considerable satisfaction a difficult obstetric case occurring in the practice of a friend.

The tumor springing from the left side, the larger of the two, is an irregularly globular fibro-cystic mass, about 23 cm. in diameter when empty, having a surface smooth above and anteriorly where it came in contact with the abdominal parieties; but behind and below irregularly nodular, made so by secondary cysts within the walls. The adhesions, not very numerous, were mostly on the lower and outer portion, but effectually bound the mass to the left side of the pelvis. The broad ligament, attached to the tumor by an area ten cm. by five cm., which formed the pedicle, lay behind and below the mass which had developed mostly upward and to the right. About 10 cm. of elongated Fallopian tube were removed, the outer or fimbriated extremity being occluded, the diameter of the tube being about 7½ mm. Just below the attachment of the broad ligament with the tumor posteriorly was a cyst oval in shape, about 6 cm. in its largest diameter, containing clear fluid; and farther down and outward one about 3 cm. in its largest diameter. Except at the smooth anterior portion the cyst wall was comparatively vascular. On section this tumor is seen to be composed of two portions, a cystic portion capable of containing about three quarts of fluid, and a semi-solid portion which lay below the other. The inner portion of the cyst is marked by irregular prominences of tissue the former partitions of contiguous cysts; in some of the smoother portions there is a harsh or gritty sensation imparted when touched, produced by minute cysts with tense walls; in other parts the inner cyst-wall is studded by cauliflower-like excresences projecting into the cavity, and being about a centimeter from base to apex. The more solid part of the tumor is composed of a reticular tissue, made so by numerous small cysts lying in close proximity to the larger ones forming projections either on the inner or outer surface.

The right cyst, the smaller one of the two, resembles the larger in external configuration and measured about 14 cm. in diameter when distended. Its surface was for the most part smooth, being transparent in places, while others were nodular from the formation of daughter cysts. This was the portion felt per vaginam as above. The walls varied in thickness from 2 to 20 millimetres.

The second case is that of an intellectual and very well preserved

woman, aged 42 years, unmarried, who has been in pretty fair health until quite recently. Her menstrual history shows that while formerly she was quite regular, the period lasted five days and the discharge was profuse, though fluid. Lately, however, the period has been irregular, too late or absent, and the discharge has been gradually getting more and more scanty, lasting mostly about one day.

She first became conscious of the presence of the tumors about five weeks ago from the fact that her abdomen began to enlarge and she had some pain and discomfort when just in the act of sitting down. From childhood on she has had occasional attacks of diarrhœa, which lately have become more severe, being unattributable to any known indiscretion in diet.

Examined externally the abdomen presented a globular shape, the measurements being: Circumference over largest part of tumor, 82 cm. ($32\frac{1}{2}$ inches); between superior spines of ilium, 33 cm. (13 inches); symphyses to umbilicus, 20 cm. (8 inches); umbilicus to ensiform cartilage, 13 cm. (5 inches).

The abdominal walls were soft and not very resistant. On deep pressure an indistinct sense of tumor was conveyed to the examining hands, most distinctly felt by the hand on the right abdominal wall. In the region of the right linea semilunaris could be felt a small, oblong, movable mass, seemingly about $2\frac{1}{2}$ cm. (1 inch) wide and $7\frac{1}{2}$ cm. (3 inches) long, which was attached at its lower extremity and permitted its upper end to move in a semicircle outward.

Per vaginam the cervix was found low down in the pelvis, anteflexed, the os in a virgin state; the fundus being pressed low down and lying in the right iliac fossa, the cavity measuring $7\frac{1}{2}$ cm. (3 inches). The pelvis was filled with a tumor which gave a peculiar sense of resistance, as of a semi-solid mass, being in some places nodular, especially on the left side.

Per rectum.—Left ovary very plainly felt anteriorly, much thickened and enlarged. The right ovary could not be recognized as such. On passing the finger up the posterior surface of the uterus the fundus could be felt round and smooth, and was readily anteverted and pushed down and out of the way, while the index finger, traversing the fundus further upward, could palpate the

mass in a most satisfactory manner. The uterus was movable separately from the enlarged left ovary, but the larger right mass and the uterus seemed to have some closer connection.

There was some doubt as to the origin of this abdominal mass, until having pushed the uterus out of the way, as above described, I felt an artery much larger than the uterine or ovarian artery, pulsating in a portion of tissue to the right and somewhat above and behind the uterus, but close to it. From this I ventured to think I could be fairly certain of having felt a large artery pulsating in the pedicle of a tumor springing from the right side of the uterus, probably ovarian; and we determined upon operation at once.

In the meanwhile our patient began to suffer from one of her attacks of diarrhœa, the stools being green mucus, with an occasional passage of formed fæcal matter. This time, however, in addition to the diarrhœa, she was markedly prostrated, had persistent vomiting and retching, with thready pulse, while the abdomen began rapidly to enlarge in every direction. She recovered from this dangerous condition, however, but had a cough remaining, apparently reflex, which she thought was made worse from any palpation of the abdomen.

The operation for the relief of this lady was undertaken on the 3d of August past, and Dr. Van Lennep very generously consented to act as my assistant. The following, taken from my case-book, may serve to give an idea of the operation.

Since seeing patient last, abdomen has become markedly distended, so that a line from pubes to ensiform cartilage is a continuously curved one.

Incision in median line, small at first, afterward enlarged, at once giving exit to a large amount of yellow, serous fluid. Inserting hand into abdominal cavity, a good-sized tumor, ovoid in form, arising from low down in the pelvis and extending upward and to the right was felt, having not many adhesions upon its surface, but having a very broad pedicle which extends from within the pelvis to its upper right brim. The small movable tumor which we felt through the abdominal wall on the right side was found to be a cyst attached near the ostium abdominale of the Fallopian tube. The tumor was partly delivered and a

trocar inserted, from which a somewhat glairy fluid escaped, having different shades of yellow color as different loculi were broken into. The pedicle, springing from close beside the uterus, and measuring 12 cm. ($4\frac{3}{4}$ inches) long, was ligated with six silk ligatures.

The left ovary was then sought for and found enlarged, lying on the left pelvic floor, was in a cystic condition, four cysts about the size of pigeon eggs showing on its surface. This degenerated ovary was tied off, in addition to about $7\frac{1}{2}$ cm. (3 inches) of hyperæmic tube, having a thickness of $7\frac{1}{2}$ millimetres.

The abdomen was then flushed with boiled distilled water, cleansed and closed with silk sutures, a small glass drainage-tube having been inserted in the lower end of the incision.

The recovery of this woman from the effects of the operation was remarkable. There was no vomiting, and nausea only lasted for a few hours. There appeared to be comparatively little prostration and the mental faculties seemed to be singularly unblunted and far different from what is usually seen or expected. Her temperature, 101, and pulse, 100, after operation began to fall at once, and in twenty-four hours was 98.4° temperature, and pulse 70. The facial expression likewise underwent a great change, becoming bright, cheerful and smiling.

The drainage-tube discharged with great freedom, overflowing everything and saturating the dressings, requiring their frequent removal. It is, perhaps, this fact which presented an entirely unincidental recovery from operation, for on the eighth day, on removing the stitches, it became evident that there would be some inflammation of three of the suture tracts and also of a place over the sacrum, induced by lying.

Description of the Tumor Springing from the Right Side.—An irregular fibro-cystic mass, weighing two pounds when empty, containing fluids of various yellow shades in the multilocular cyst. Tumor mass when empty measures 12 cm. ($4\frac{3}{4}$ inches) in diameter, and is composed of two parts, a semi-solid and a cystic portion. The part which lay most deeply in the pelvis and was nearest the uterus is the semi-solid part, this being soft and red on section; the cystic portion lying farthest from the median line and above the other, the most of it being extra-pelvic.

On the tumor mass is an irregularly circular surface about 7 cm. in diameter, denuded of peritonæum, which is the site of the pedicle. This surface is continued outward in a narrow strip about 5 cm. long, and also denuded of peritonæum, in which are numerous vessels averaging from 1 mm. to 2 mm. in diameter. This narrower site of the pedicle extended backwards and to the right in the abdomen, and was connected with the upper portion of the pelvis.

Along one portion of the tumor is the greatly elongated Fallopian tube, of which 13 cm. have been removed with the tumor, measuring 4 mm. in diameter. The fimbriated extremity of the tube appears to be closed, and an ovoid cyst 2 by 2½ cm. in diameter is situated in what corresponds to the margin of meso-salpinx or the so-called infundibular pelvic ligament.

The tumor mass is irregularly nodular, some of the nodules being covered by cysts 4 cm. in diameter, which in some instances appear pale-yellow in color, in others dark, as if containing changed blood.

The left ovarian tumor is an irregular fibro-cystic mass measuring 6 cm. wide, 7 cm. long, and 3 cm. thick, on one surface of which is an ovoid cyst about 4 cm. in its largest diameter, and two other cysts 2 cm. in diameter, beside a number of smaller ones.

On section this tumor is quite soft to touch, red in color, the cysts containing a thick fluid mostly yellow in color. The Fallopian tube of this left side, lost after removal, was bright red in color, inflamed, and measured about 7½ mm. in diameter and was also elongated, about 6 cm. having been removed with the tumor.

Microscopic Examinations.—Sections of the tumors, of which I have made quite a number, present the usual interesting and beautiful appearance of such growths. In addition, this series of four tumors affords an opportunity of observing many of the stages of growth through which the proliferating papillomatous cyst passes.

The larger left tumor of the first case is the one farthest advanced, and is in the condition presented by most tumors which have been permitted to become large before their removal, that is, the larger part of the solid portion being cyst-wall.

Lower in the series is the right smaller cyst from the first case. In this an excellent opportunity is presented for studying the

formation of the so-called daughter cysts, the walls being much thicker in places from the development of many smaller cysts within them. In this, likewise, the dentritic appearance of the papillomatous growths may be viewed in a typical state.

In the larger right tumor of the second case the most abundant proliferation of papillomatous tissue exists, the larger part of the mass remaining after evacuation of the cyst, being of this tissue, and not as in the larger tumor of the first case, merely cyst-wall.

The smaller tumor of the series being from the left side of the second case, is one of great interest. In it the most early evidence and manner of cyst-formation presented by this series, may be studied; and while this has already passed considerably beyond the stage when normal ovarian structure may be readily demonstrated, it still shows the cysts small, some 3 mm. or 4 mm. in diameter and filled by a most beautiful development of papillomatous formation.

In conclusion a fact should be recorded. In making another careful examination of these specimens recently, I discovered the fact that in both tumors from the second case, the papillomatous growths had perforated the walls of each tumor and appeared as a slightly raised patch about 2 cm. across on their outer surface. This fact is of some importance, as demonstrating another typical feature of this particular class of cystomata; as throwing considerable light on the clinical history of the patient, and verifying the opinion of her attending physician, Dr. Barnes, that the growths would prove to be malignant.

BUREAU OF PATHOLOGY.

A Case of Extrophy of the Bladder: A Post-mortem Examination, by Landreth W. Thompson, M.D.

Strain as a Factor in the Production of Pulmonary Phthisis, by W. C. Goodno M.D.

A CASE OF EXTROPHY OF THE BLADDER: A POST-MORTEM.

LANDRETH W. THOMPSON, M.D., PHILADELPHIA.

THE patient in whom I found this interesting deformity was a young girl of about fifteen years. Her previous health had been good. She was in vigorous condition at the beginning of her illness. The utmost care was, however, always required to hold in check the irritation caused by the constant flow of urine over her body and limbs.

One word in regard to her illness. She began with the ordinary symptoms of typhoid fever. Her temperature rapidly reached 105° and 106°, and continued so for days, only remitting to 102° and 103° under the repeated use of antifebrin. At about the fourth week she had numerous severe, intestinal hæmorrhages which reduced her exceedingly. When these had ceased, an acute gastric catarrh set in and consequent nutritive failure, from which she died at the end of the fifth week. Her sufferings must undoubtedly have been aggravated by the condition of the urinary apparatus; and this in turn must have been a serious drain upon her strength. For along with the urine came a continuous stream of calcareous matter, which not only adhered to the already excoriated pubic and pelvic region, but actually seemed to grow into the tissue. When, finally, despite the most careful watching the skin broke over the sacrum and great trochanters, this sandy urine flowed down into whichever was, at the time, the most

dependent sore, making it almost impossible to obtain even the slightest improvement in them.

At my earnest solicitation a post-mortem was allowed and made by Dr. R. B. Weaver, Demonstrator of Anatomy at the Hahnemann Medical College. I regret that neither of the two plates exposed at the time shows accurately the anomaly.

In stature she was short; her body especially broad at the hips. The pubic bones were separated anteriorly by a distance of five and a half inches. A normal growth of hair occupied the lateral aspects, but did not meet in the centre by about four inches. The anus was in normal position, the perinæum wide and rather deep antero-posteriorly, the vaginal orifice transverse and not readily detected, owing to the excoriated and turgid condition of the parts. Here and above the skin was deeply injected and nearly covered with calcareous scales. Above the line of the vaginal orifice and separated by about two and one-half inches were two ill-developed labia. They were independent of any bands or furrows connecting them with the surrounding structures, seemingly just set down upon the general surface. At a distance of about one and one-quarter inch above the vagina were two deeply red prominences about as large as a small chestnut. These had always been exceedingly sensitive and frequently bled more or less profusely. Directly above these papillæ was a transverse sulcus about five-eighths of an inch deep. At the bottom of this sulcus were the openings of the ureters. They were not easily seen, but, when found, were clear of any granulations or other structure which might obstruct the flow of urine. The upper border of the sulcus joined the area of highly inflamed mucous-membrane-like tissue which corresponded to the posterior wall of the bladder. This area could be covered by a silver quarter.

Internally the pelvis was large, the uterus normal in appearance, as were the tubes and ovaries. The right ureter about normal in size, except slight dilation near its opening and it contained no detritus. The left ureter, even though shrivelled with the embalming fluid, was large through its entire extent; in both the calibre was large and the walls much thickened. The pelves of both kidneys were also enlarged. The kidneys themselves

rather over-size, but, on section, no macroscopic changes were detected therein, with the single exception that the pelvis of the left kidney and the entire left ureter were filled with this same calcareous sand which covered the external genital region. The intestines were covered with a long omentum and the only peculiarities noted were a few adhesions in their course. The stomach was of very peculiar shape, viz., almost exactly resembling a boot. There did not seem to be any determining cause for the same, unless the pressure of a rather large liver, together with the lack of support to the lower abdomen, might eventually cause it.

The recti muscles came normally down below the umbilicus and there either faded gradually into the aponeurotic tissue, or, parting company, may have sent fibres to the widely separated pubic bones. This gave a large triangular inter-space (its apex one and one-half inches below the umbilicus, its base the line of the vaginal opening), composed of skin and very scanty connective tissue, a thin parchment-like aponeurosis and peritonæum. Taken together these structures were scarcely the eighth of an inch in thickness.

The case then presents the following characteristics: First, it was a female, while the anomaly occurs almost universally in males. Second, the almost entire absence of external genitalia. Third, the extreme thinness of the lower abdominal walls. Fourth, the pubic bones being present but so widely separated. In fact, the whole case looked as though an incision had been made from the upper part of the bladder through its anterior wall, through the symphysis pubis and through the upper wall of the urethra, the whole drawn forcibly apart and allowed to heal thus.

Regarding the treatment of this condition, there are two indications: First, the protection of the overly sensitive granulation tissue composing the posterior bladder-wall; and second, the control of the flow of urine.

Theoretically a cup-shaped shield moulded over the parts and connected with a proper receptacle on the thigh would perfectly fulfil these indications. The difficulties, however, render this of almost no service; because the cup must be large to cover the irregular surface and consequently every motion of the limbs and abdominal walls would cause great leakage around its sides.

Permanent tubes held in the opening of the ureters are open to objections just as forcible as the above.

Two methods of securing a receptacle for the urine in the body itself, are: First, directing it into rectum or vagina, and secondly, the formation of a new anterior bladder wall by a more or less extensive plastic operation.

If we open the ureter into the rectum our patient is subjected not only to the liability of a most annoying train of rectal symptoms, but also the danger of renal infection through the pathway thus opened.

Much more promising is the attempt to form a new bladder wall by one or other of the proposed methods, which we can briefly describe as turning a flap upward from the perinæum, as is done in Maury's operation or from the anterior abdomen downward as in Wood's operation, then bringing lateral flaps over and covering in the raw surface of this first flap. Either of these gives a cavity (unfortunately though with no sphincter control) which will, however, hold a greater or less quantity of urine.

There is one other point wherein these flap operations are of great service to the patient, viz.: In covering the hyper-sensitive granulations which are so exceedingly in the way of the patient's enjoyment of life.

Two lessons were strongly impressed upon me by this post-mortem. First, the extreme thinness of the abdominal walls for a distance of fully three inches around the ureteral opening would have made it almost impossible to obtain flaps with sufficient thickness to have any vitality at all and at the same time large enough to cover the space requiring it. The dissection would almost certainly have opened the abdominal cavity.

Secondly, the thought occurred to me (and had the case recovered, I should have made the attempt), to obliterate the sensitive and exposed areas by the freshening of those areas and the transplantation of pieces of skin taken from other portions of the patient's body and so reduce to the very minimum the distress to which she had been subjected. Besides, I suggest that the very fact of having such a decreased area of over-sensitive tissue might have given us a chance to have fitted a partially satisfactory urinal and thus made her at least less of a care.

STRAIN AS A FACTOR IN THE PRODUCTION OF PULMONARY PHTHISIS.

W. C. GOODNO, M.D., PHILADELPHIA.

It is well known that a large percentage of athletes die of pulmonary phthisis, a percentage too large to be accounted for by the exposure and dissipation to which many of them subject themselves. This observation has been recorded concerning professional athletes only, at least so far as the writer is aware. The histories of a few cases which I present to this Society to-day suggest that the influence of this cause is not confined to that class of individuals. In attributing these cases to strain, at least as the most potent factor, I am well aware of the sources of error in making such a deduction, and have endeavored by most careful analysis to arrive at the facts in each case.

The vulnerability of the pulmonary tissues differs within quite wide limits, as can be easily determined in observing the influence of the various well-known causes of pulmonary disease. Not only is there this general variation in susceptibility, but an equally variable response to individual causes. This seems true respecting the influence of strain. As has been observed, *professional* athletes very frequently die of phthisis. These persons suffer from the influence of strain in its highest degree, and quite continuously. Many of this class, even with good family histories and an absence of other predisposing causes, succumb early, while others resist for years. We must remember that the "survival of the fittest" applies to them—that they have become professionals because their exceptional physical development and powers of endurance have enabled them to accomplish physical feats which are beyond men of ordinary development, and they are therefore presumably and undoubtedly on a higher plane physically than the ordinary man as represented by the average college student.

The source of the cases which support the strain hypothesis is, in the main, the various institutions of learning devoted to men. I have observed no cases among women. The extent to which the athletic craze is being carried by our colleges is alarming, not

only on account of its influence upon the lungs and heart, but upon the entire organization. It is in violation of good sense and of well established physiological and pathological laws. Of the value of well-regulated, systematic exercise, none doubt, but to the serious injury which is being done to many of the flower of the land by injudicious action on the part of our great institutions of learning, I am afraid we are not fully awake. Many of these institutions have directors of physical culture, and, occasionally, such gentlemen are members of the medical profession. Parents permit that which does not agree with their better judgment, because their son's exercise is directed by a physician, and surely a physician must know. But, unfortunately, most who follow athletics, even physicians, allow their love of sports, their ideas of what it is possible, through cultivation, to make of the human form divine, to over-persuade their judgments. I feel convinced that the terrible strain of muscle, and all muscular organs, especially the heart; the greatly increased blood-pressure, endangering the integrity of the bloodvessels, if organically weak; and their future nutrition, as well as that of the tissues supplied by them, even if sound; the almost agony of mind, as the enthusiast nears the goal—are only warrantable to preserve one's very existence. Such efforts, as a means of perfecting the physical organism, are on a par with harrowing trouble as a means of mental strength and peace.

Case I.—Professional gentleman, æt. 31; height, 5 feet 10½ inches; weight, about 179 pounds; graduate of Yale. Parents living, and well. No history of phthisis in either branch of the family. It is barely possible an aunt, who has suffered from cough, has it. But, upon the father's and mother's side, all are well-developed, healthy-looking people. The subject of this report was a healthy boy, who suffered from some of the diseases incident to childhood, but none in serious form, nor did any of them—such as whooping-cough, leave him with cough or any unusual deterioration of health. He entered Yale at the age of 19 years, and pursued a full course, graduating with honor. He occupied a light, well-ventilated and well-located room, and slept alone. His room-mate was healthy. During this period, he was continuously at the front in all forms of athletic sports, especially rowing. Without colds (for he was a very prudent man and not

at all subject to them), he developed a slight hacking cough during the latter portion of his student life. This was aggravated by exercise, but never sufficiently prominent to cause a feeling that there was anything of importance ailing him. After his graduation, his general health was not good. He was treated a little, but nothing discovered wrong with his lungs—probably because examinations were superficial, and of this there seemed to be evidence. Cough gradually increased, however, and expectoration became profuse.

After the cough and expectoration had been pronounced for one year, I saw him in consultation, and found marked evidences of fibroid phthisis, involving the right lung, upper lobe. The retraction of the chest over this point was decided. With the early development of cough it was noticed that the breathing was not as free as formerly.

A period of comparative freedom from exercise relieved, and full indulgence aggravated the symptoms. His health, he feels, was perfect until twelve months after entering school.

Case II.—A young man of eighteen years, in whose family I have been the regular medical attendant for a dozen years, consulted me concerning certain symptoms which developed during a foot-race. I learned that he was foremost in all the athletic sports, running and rowing races, and playing at foot-ball, etc. He was tall, with a fine, muscular-looking physique, and was eminent among his fellows, at the college where he studied, for his ability in most of the games and exercises. At the time of consulting me he was preparing for both running and rowing races. His family history was good; both parents living, and in robust health; four brothers and sisters, all well; their grandparents living; none phthisical. Cannot get an authentic history of pulmonary disease in any branch of the family.

The attack for which I was consulted was a sudden one, coming on near the close of a running exercise. He was giddy, confused, short of breath, and it was several days before the symptoms disappeared entirely. I could not detect any cardiac cause for the attack, *i.e.*, upon physical examination. A refusal to consent to his return to preparation for the races, brought urgent requests from the director of physical culture, and later, from the president, that I should consent, as, in their opinion, the trouble was

transient, and the exercise would do him no harm. Still refusing, and the father of the young man agreeing with me, the son declined to continue his athletic work. From this time on, without apparent reason, he was not well—attacks of hoarseness, and a little cough, and later, more continuous cough with expectoration. Without a positive intermission in symptoms, at any time, there was a continuous increase of cough, expectoration, hoarseness, chest-pains, some dyspnœa, loss of flesh, etc. Physical examination demonstrated gradually progressing lung consolidation, and evidences of localized bronchitis at both apices. The areas were small, but perfectly distinct. The physical condition and symptoms remained about stationary for a year, and then gradually improved. The man is in pretty good health now, but physical examination still reveals apical consolidations. The lesion is probably undergoing fibrous transformation, brought about by his naturally good constitution and the faithful carrying out of treatment. Pulmonary trouble, in some character or degree, undoubtedly antedated the attack referred to, as a careful inquiry showed that there was an almost unnoticed cough, with less breath for his hard work than usual, for some little time prior to his giving out.

The relationship existing between strain and pulmonory phthisis would seem to be simple. The active congestion of the pulmonary tissues induced by each effort fails, after a time, to disappear with rest, and a chronic passive engorgement becomes the habitual state of these organs. In addition to this, the fibrous, and indeed all the tissue elements of the lung, are disturbed in their nutrition by the frequently repeated violent strain to which they are subjected. An inflammatory disposition is established, and the ever-ready and widely-spread bacillus of Koch fans into activity and type the smouldering inflammation. It is possible that the frequent distension of the pulmonary alveoli leads to a dilation of the lymph spaces communicating with the interior of the alveoli, which are, indeed, lymph cavities, and thus renders ingress into the tissues, and especially into the lymph-sheaths of the blood-vessels, more easy, and the spread of the disease more rapid. The practical feature, however, is most important: Pulmonary phthisis is favored by injudicious strain, and we should endeavor to bring about suitable reforms in the methods adopted in our colleges for the physical culture of the rising generation.

BUREAU OF OPHTHALMOLOGY, OTOLOGY AND LARYNGOLOGY.

A Case of Melano-Sarcoma of the Nares, by I. G. Shallcross, M.D.
Lachrymation, by W. H Bigler, M.D.
Headaches, by H. K. Hoy, M.D.
Mastoid Abscesses, by R. W. McClelland, M.D.
Punctured and Penetrating Wounds of the Eye, by W. W. Speakman, M.D.
The Treatment of Atrophic Rhinitis, by H. F. Ivins, M.D.

A CASE OF MELANOTIC SARCOMA OF THE NARES.

I. G. SHALLCROSS, M.D., PHILADELPHIA.

Of about forty reported cases of sarcoma in the nasal passages, four have been melanotic. The case reported here is that of a German lady, æt. 72 years, who applied at the Hahnemann Dispensary, August 7, 1891, for what had been called a polyp of the nares. A year ago she was quite stout, but is now emaciated. She complained of not feeling strong enough to attend to her household duties. Last summer she had "la grippe." As this catarrhal trouble disappeared, she noticed a stuffiness of the left nostril, gradually increasing to complete stenosis. In April she consulted a physician, who removed part of the growth with a pair of scissors. This operation was followed by a profuse hæmorrhage, lasting two hours. Four weeks after the first operation the growth recurred, and again a portion of the tumor was removed. This time the bleeding was controlled in one hour. During the three months following nothing was done for her condition, although the tumor continued to grow, complete stenosis again resulting. For six weeks previous to applying at the dispensary she

had frequent attacks of epistaxis, pain developed around the left eye, and she lost strength and flesh rapidly. At times, she was flighty in her conversation.

The nose was considerably bulged on the left side, otherwise nothing could be seen externally. Separating the alæ of the left nostril, a large bluish-black growth, entirely filling the anterior nares, almost protruded from the nose. There was a profuse sero-sanguinolent discharge and slight fetor. The growth was very slightly movable, of a boggy consistence, and attached to the triangular cartilage of the septum by a broad, flat pedicle.

Fig. 1.

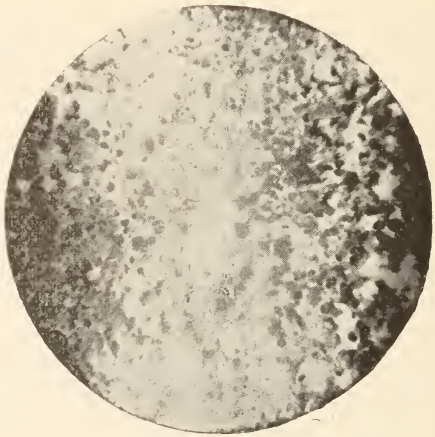
Appearance of Tumor Before Operation.

There were, also, adhesions to the middle and inferior turbinated bones. The right nostril was perfectly normal, except for a slight deflection of the septum, due to the pressure of the tumor on the left side. A post-nasal examination, with Frænkel's rhinoscope, revealed nothing abnormal. The lymphatics were not involved.

On August 15th, she submitted to an operation for removal. A four per cent. solution of cocaïne was applied to the mucous membrane, and an attempt made to remove the tumor by means

of a Sajous snare. About one-third was removed in this way. Failing to snare more of the growth, even after breaking up the adhesion to the turbinated bones, I employed the sharp spoon, and by this means removed the entire growth, the tissue breaking down readily. It now became necessary to tampon the nares in order to control hæmorrhage, which was quite profuse. In about ten minutes the tampon was removed, and the entire anterior two-thirds of the nares tightly packed with iodoform gauze. This was allowed to remain for three days, when it was removed and the nares cleansed with an antiseptic solution, after which it was redressed

Fig. 2.



Showing Pigment.

with the gauze. On August 22d, the base was thoroughly curetted, and cauterized with chromic acid, and again packed with the iodoform gauze, which was removed at the end of three days.

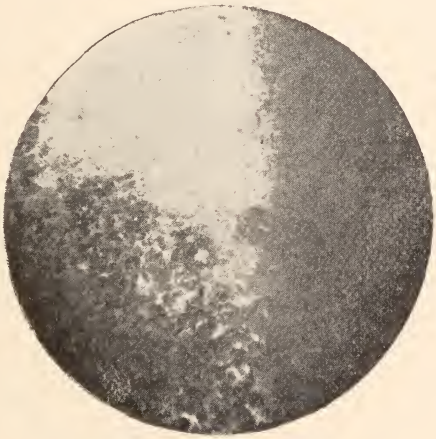
September 8th, she reports still feeling weak. There has been no recurrence of the epistaxis, the pain is entirely gone, and her mind is clear.

The future treatment of the case will consist in frequent cleansings with antiseptic solutions, and the administration of such remedies as her symptoms may indicate. The case will be carefully watched and the slightest recurrence will be met by prompt curetting and cauterization. Should I not be able to control and

eradicate it by such means, the entire triangular cartilage to which the original growth was attached will be removed.

Several pieces of the growth were kept for microscopic examination, and these examinations revealed a round-celled sarcoma, fully one-third of the cells and much of the intercellular substance being colored with a dark-brown pigment, proving the case to be one of round-celled melanotic sarcoma. Numerous hæmorrhages had taken place in the tumor, and around the edges of the hæmorrhagic points were found marked necrosis.

Fig. 3.



Showing Hæmorrhage and Necrosis.

In conclusion, I must mention the fact that, when this patient first applied at the dispensary, on August 7th, hamamelis was prescribed with the happy result of checking the epistaxis, there being no return during the time intervening between August 7th and the date of the operation, August 15th. At present, I believe china to be the remedy most thoroughly indicated in her case, but I have in mind such remedies as arsenicum, carbolic acid, hydrastis, thuja, conium, calcarea carbonica, phosphorus, phytolacca, sepia, and silicia. Considering the great malignancy of these tumors, however, I am firmly convinced that they should be reremoved immediately, if operation is possible.

LACHRYMATION.

W. H. BIGLER, M.D., PHILADELPHIA.

It is not my intention to endeavor to present anything new on the subject of lachrymation, but merely to arrange in a systematic order the various causes of this frequently occurring symptom, and thereby to assist in the successful application of the numerous remedies suggested for its removal. By lachrymation we mean an excess of tears in the conjunctival sac, causing an overflow, and due either to an excess in the amount secreted—properly called epiphora, or to a deficiency in the means of drainage, for which *stillicidium lachrymarum* is the correct term.

A hypersecretion of tears is due in all cases, of course, to an affection of the lachrymal gland, be it by disease or by reflex action.

Diseases of the gland—such as dacryo-adenitis (inflammation), dacryops (cysts), or fistula, as the consequence of either, are only at times attended by a hypersecretion of tears, and never only, or usually in the beginning of their course.

Affections of a functional nature, the result of reflex action, are much more common causes of an excess of secretion.

Thus we have as most frequent causes of lachrymation: 1. Affections of the conjunctiva, irritation (*e.g.*, from wind or from foreign bodies); or inflammation. 2. Affections of the cornea and iris, or ulcerations and inflammations of the deeper tissues of the eye, usually attended with blepharo-spasm (*e.g.*, the effects of bright light, over-exertion of the muscles of accommodation). 3. Neuralgias of the trigeminus, especially of the first and second branches. With the lachrymation due to the emotions, also to the mechanical pressure in gaping, etc., we have nothing to do.

Deficiency in the means of drainage depends upon some anomaly of the lachrymal apparatus, the puncta, the canaliculi, the lachrymal sac, or the nasal duct.

The anomalies of the puncta are displacement, obstruction or obliteration. We would wish to call particular attention to the first, as one of the most fruitful causes of lachrymation, and one

of the most neglected. A case of ectropium, or scar, from nerve or other injury causing the same condition, can be, and usually is easily recognized as the cause of an overflow of tears, but the slight misplacement, the scarcely perceptible want of coaptation of the punctum to the ball, due perhaps to some trifling marginal blepharitis, or to a swollen conjunctiva, in chronic conjunctivitis, or—as is frequently the case, to a lax condition of the skin and fibres of the orbicularis muscle in the aged—these are not so readily recognized nor so often looked for. The want of coaptation of the punctum to the ball is often so slight in degree as to require for discovery careful examination with the ball and lid in perfect rest. The punctum need not be pushed forward away from the surface of the eyeball; a vertical direction is enough to prevent the tears from finding their way into the canaliculus. It is easily seen that it takes but a very mild case of chronic conjunctivitis, so common with the old, to produce a swelling of the inner surface of the lid, enough to cause the punctum to be turned directly upward, instead of in and up against the ball.

A slight contraction of the under skin-surface of the lower lid from an eczematous condition may easily produce the same result.

Obstruction or obliteration of the punctum and canaliculus may arise from the presence of a foreign body, a hair, or a small calcareous concretion, neither very common; or more frequently from a swollen condition of the lining mucous membrane, due to an extension of inflammation downward from the conjunctival sac, or upward from the nasal cavities, resulting frequently in stricture of the duct. The latter case is one that often fails to be recognized. Another neglected cause of obstruction is the extension of a marginal blepharitis in which the punctum becomes glazed over if not blocked up by the secretion. For some years past stricture of the nasal duct was almost the only cause practically recognized, and a watery eye was almost invariably an indication for the use of the knife and probe. As has become customary in this day of rapid progress, a reaction has set in, and discontent with the results of this mode of treatment has become wide-spread, and has led to closer individualization and more rational treatment. The probe is often used without the knife, and external and internal medication often without either.

As can readily be seen the simple symptom *lachrymation*, can prove but a poor indication in the choice of a Homœopathic remedy, and even a so-called "totality of symptoms," laying stress upon concomitants and consequences necessary to the condition, is no reliable guide unless it include as the most prominent factor the *cause* of the trouble.

When the cause is in the conjunctival sac, boric acid, or zinc sulphate externally applied are the most reliable adjuvants. These same in connection with the passing of the smaller probes, without slitting up the canaliculus, I have found in at least half my cases as successful as the more radical treatment, when the drainage system is affected, without complete stricture. In the latter case the opening of the canaliculus becomes necessary in order to allow of the passage of the larger probes with the least discomfort. In all cases the Homœopathic remedy addressed to the cause is necessary to a permanent cure.

HEADACHES.

H. K. HOY, M.D., BELLEFONTE.

PAINS in the head enter so largely into the rehearsal of symptoms by our patients that he is indeed fortunate who can unerringly find the appropriate remedy, or discern the underlying cause. Since headaches are but a series of symptoms of present existing or remote causes, it is often imperative that the cause be ascertained and removed or corrected before we can bring about the relief sought for. Should these head symptoms be present in the course of ordinary diseases, we all know that proper prescribing and patience will help us out if the malady is one possible of cure. The effects of a cold must be removed, the stomach and liver seen to when symptoms show them disordered or torpid, inflammatory conditions must be subdued, carious teeth must be extracted, in fact all symptoms pointing towards diseased parts, as well as the head symptoms themselves, must be remedially treated, and at the same time we must not forget to look for headache causes, aside from those to which the symptoms directly turn our attention.

It has lately become a very common thing to blame our poor eyes for many of our so-called headaches, and I shall cite several cases from practice to illustrate the subject under consideration.

Occasionally a patient presents himself complaining of periodical headaches, appearing say once per week or once per month. Upon testing the eyes it is found that some of these patients, although they may be able to read $\frac{10}{10}$, accept a + spherical anywhere from + $\frac{1}{44}$ to + $\frac{1}{48}$, or possibly they can only read $\frac{10}{15}$ or $\frac{10}{20}$ and a + spherical enables them to read $\frac{10}{10}$. In either case we suspect hypermetropia, and again where vision is limited and a + spherical is then alone or combined with some other lens simply improves the sight, leaving some asthenopia unaccounted for. Under any of these circumstances a proper correction often cures the headache where remedies would fail. These cases are very important, especially the former ones, in so far that the cause might be entirely overlooked and the physician's labor lost, and only disappointment to him and his patient follow.

I shall now cite a few cases:

Case I.—Mrs. U., age 28, has slight headache all the time, but every week or two has deathly sick headaches, and this has been a life experience. The patient is of a bilious temperament, and presents the multitude of symptoms of the dyspeptic. Eye testing reveals R. V. $\frac{10}{20}$, L. V. $\frac{10}{40}$ + $\frac{1}{50}$ spherical improves R. V. and + $\frac{1}{48}$ c ax. 90° improves L. V. This correction was made February 14, 1888, and the improvement from that time to the present is so great that the patient will not do without the glasses, although at times when run down, or the stomach disordered, or at menstrual time, attacks of headache came on, but in a milder form than before correction.

Case II.—Mrs. L., age 35, has all her lifetime been subject to headaches; scarcely a day can she recall when she was free from pain. The pains increase as she becomes fatigued, worse when she looks at anything closely, as when sewing or reading; when reading the letters seem to run together. Upon testing the eyes she reads $\frac{10}{15}$ each eye; + $\frac{1}{54}$ spherical enables her to read $\frac{10}{10}$. This correction was made February 28, 1888, and since then the constant use of these lenses has entirely relieved the head pains.

Case III.—This case will be recorded because it is interesting,

although it may be somewhat out of the line of cases proposed. Mrs. B., aged 65, comes complaining of general neuralgic pains, which first appeared about thirty-five years ago, and mostly in the head and about the eyes. Soon after affecting the right eye it began to fail and finally the sight was lost. Upon October 5, 1890, the patient applied to me for treatment for pains in the head and extremities. In summarizing the symptoms I decided to give chamomila 6x tablets, one every three hours. The lady remained under treatment until November 24th, following, receiving her last prescription upon that day, and since then she has been free from the pains, which for thirty-five years have been the terror of her life. About three months ago she applied to me for spectacles, as she found her sight going rapidly in the other eye. In the right eye, the one that had been sightless for over thirty years, there was the appearance of a cataract, with perception of light sufficient to discern daylight from darkness, and had it not been for the history of the manner in which the eye was lost I should have promised much from the cataract operation. As it was I was guarded in my prognosis, but I advised the extraction of the lens, to which consent was readily given, and I removed a calcified lens. After the healing from the operation I found the retina destroyed. It presented a wash-leather appearance, and there was no improvement in the sight beyond a bare perception of light. When she presented herself the vision in left eye was $\frac{10}{70}$ with no improvement by the application of trial glasses, and ocular and lens inspection revealed oncoming cataract in that eye.

Case IV.—Miss M., aged 18, has been a constant sufferer from pains through temples and on top of head. Not a day can be remembered but that the headache has been present. She also complains very much of pains in small of back and lower down. Uterine trouble is suspected but as yet no examination is allowed. The eyes were tested July 30, 1871, under homatropine, and with the result that finally a $+\frac{1}{30}$ combined with $+\frac{1}{30}^{c}$ ax. 30° was applied to right eye and $+\frac{1}{30}$ combined with $+\frac{1}{30}^{c}$ ax. 150° was applied to left eye. Under the use of these lenses, three weeks of comfort have been enjoyed so far as the head symptoms are concerned, but the pains in the back are still present.

PENETRATING WOUNDS OF THE EYE.

W. W. SPEAKMAN, M.D., PHILADELPHIA.

In the consideration of penetrating wounds of the eye it is the intention of the writer to treat only of those cases in which a foreign body has not remained in the eye, but where there has merely been a penetrating wound, affecting to a greater or less extent the integrity of the organ.

The size, shape, position, and varying other conditions with which we meet in these injuries, makes it clearly impossible to lay down any certain rules of procedure for all cases, each having to be governed by the facts and conditions pertinent to it. Yet wounds of this kind are of daily occurrence, each requiring in their line prompt and proper treatment. The usual first principles observed for the treatment of wounds in other parts of the body, of course still remains necessary here, and the removal of any foreign body from the wound, provided it can be done without still greater injury to the eyes is always in order.

Perfect asepsis, so far as we can reach that degree, is undoubtedly the key-note of success in these cases, and without it we have little to hope for.

The eye and surrounding tissues should be scrubbed and washed with bichloride solution, as should the hands and instruments of the operator. With perfect freedom from all foreign particles, and with careful and aseptic dressings, we have only to combat the direct effects of the wounds, and we put matters on a basis where nature can exert herself to the best advantage.

Absolute cleansing, then, and the coaptation of the parts should be our first thought, together with rest and non-use of the organ.

For convenience I shall take up the various seats of injury, structurally, and as briefly as possible outline them.

Wounds of the conjunctiva are usually of minor importance, owing to the superficial locality of the membrane, and to its vascularity; however, when they are situated in the fornix, or should the bulbar and palpebral conjunctiva be injured in approximate positions, we are in danger of a resulting symblepharon.

As in all cases the character of the penetrating body, the smoothness of the incision, the freedom from contusion and bruising, the more quickly and surely will union take place. Hæmorrhage and suffusion of blood are usually present, depending on the size and character of the injury.

The wound may heal by first intention or by granulation. When by the latter the granulations may raise themselves above the surrounding conjunctiva, and finally become attached only by a pedicle, which may be snipped off and the base cauterized.

The treatment is usually easily determined. Should the conjunctiva gape considerably, exposing the sclerotic, it may be drawn together by sutures, or should its edges be ragged and torn, we should not hesitate to trim them off and then coapt by stitches. Should the wound be deep enough to cause laceration or even division of any of the recti muscles, interference with the mobility of the ball will result with possible attending diplopia. If seen early we may make an effort to correct this by a deep suture, or an advancement in the more remote cases.

Wounds affecting the sclerotic, whether large or small, are always of serious import, for they admit the possibility of loss of vitreous, injury to the ciliary body, and prolapse of a portion of the uveal tract. In the first instance should the loss of vitreous be trifling and union take place kindly, and if the wound be well back of the ciliary region, we may give, on the whole, a moderately favorable prognosis. But if, on the other hand, the escape of vitreous be extreme, the eye may be endangered by intra-ocular hæmorrhage and suppurative changes. Wounds affecting the ciliary region near the corneo-scleral margin are especially dangerous, frequently causing sympathetic irido-choroiditis in the sound eye, either at once or by the cicatrization and hardening subsequent to the healing.

Again, if the uveal tract be drawn into the cicatrix, we may have resulting, as has been shown by Von Graife, limitation of the field and even detachment of the retina.

Should the wound be long and clean cut it may be practicable to insert sutures, as practiced by Bowman, Lawson, and others, provided it does not endanger a further loss of vitreous.

As the sclerotic tissue heals but slowly, it is always well for the

patient to remain quiet for several weeks, wearing a light flannel bandage, which shall exert gentle and uniform pressure. Coughing, straining at stool, or any violent exertion should be carefully guarded against. The treatment is, then, upon the whole, mainly an expectant one, namely rest, the instillation of atropine to relax the uveal tract, a light pressure bandage and the addition of cold in the shape of ice or cold cloths. In those cases in which the wound is large and in the ciliary region, and we feel reasonably sure that the lens is injured, it is a question if prompt enucleation is not the best treatment.

The cornea is not infrequently the seat of penetrating wounds, with or without injury to the iris or lens.

These cases may or may not be readily diagnosed, depending on the size, character and position of the injury, and the length of time it has existed. Should inflammation or suppuration have intervened, or the contents of the anterior chamber, or the cornea itself, have become hazy, it may be difficult to say whether the conditions present resulted from a penetration or a contusion. Shallowness of the anterior chamber, attachment to, or protrusion of, the iris from the cornea, a gap in the iris, blood in the anterior chamber or the existence of the opening itself, are the prominent symptoms. In old cases, where injury has not been extensive, it may be difficult to tell, except by careful focal illumination, whether the condition present is due to penetration or simple perforation.

The prognosis, of course, as in the preceeding cases, is influenced by the character and extent of the lesion, and by the entanglement or non-entanglement of the iris, by the position occupied by the wound, whether it be central or at the sclero-corneal margin (the one affecting the vision and the other the ciliary body).

The probability of a scar or macula resulting depends on the depth of the wound, the progress it makes in healing and the age and condition of the patient, should it not penetrate deeper than Decemet's membrane. If healing be rapid and if the patient be young the chances for little or no scarring of the cornea are good.

The vision may be interfered with by the preceding course, by irregularity in the refraction, by anterior-staphyloma, and by the iris being drawn over the pupillary area.

Cystoid cicatrization of the cornea is occasionally a sequela, and is produced by the union simply of the conjunctiva and not of the firmer tissues of the sclerotic, the intra-ocular pressure from behind being sufficient to force the non-resisting wall forward. A fistula from incomplete closure of the wound may also occur. The treatment, to be successful, should in all cases be instituted early.

I have in mind two cases in which entanglement of the iris in the wound was successfully released by the prompt instillation of atropine and gentle manipulation of the ball through the lid. These cases were, however, seen immediately after the injury, which in one instance was caused by the sharp blade of a pair of scissors, and in the other by a penknife. Had several hours or days elapsed adhesions would have formed which might have been difficult or impossible to break up.

Rapid dilatation, then, of the pupil is usually indicated, except where the wound be at the periphery, and it is necessary to disentangle the iris at its junction with the ciliary body, when eserine should be used.

The application of cold, depending, as in the case of the sclerotic, on the extent of the injury, may be advisable should the iris protrude, and, should the case be seen early, it may be advisable to attempt its return by the use of the Daviel scoop, but we should always remember how prone that tissue is to inflammation after manipulation.

If, however, we cannot safely return it, we may remove it by clipping close to the ball with the scissors.

Permanent attachment of the iris to the cornea must be regarded as a more or less constant menace to the eye on account of the dragging on the ciliary body. Wounds of the lens are usually accompanied by the lodgment of a foreign body which would bring them outside the scope of this paper. However, there are cases in which a penetrating body, such as a splinter of wood, or the point of a knife, ruptures or effects entrance into the capsule without remaining. The wound in the capsule will usually be visible at once, or within a few hours after the injury, and will soon become hazy.

This opacity is supposed to be due to the contact of the aqueous

humor to the lens substance, and the breaking up of the consecutive layers of the lens fibres.

If the wound be extensive, rapid swelling and increase in the tension may immediately ensue. The corneal wound should be sought for; for although it may be far distant from the wound in the lens, it may give us some idea of the size and extent of the latter. If it should be thought best not to enucleate, we should carefully watch the tension and apply cold compresses and give absolute rest.

Opacities of greater or less extent are sure to follow where the lens or capsule has been entered. This may proceed to completeness or only a small portion may be involved and then become stationary.

Tho prognosis is, on the whole, unfavorable, but depends, of course, upon the path which the body has made in reaching the lens. Should it lie in the line of the ciliary body, with loss of vitreous, we might as well proceed to enucleation at once. In all cases where it is uncertain as to whether or not the lens has been injured, we should cautiously await developments. Instil atropine or eserine, as may be best indicated. The remedy for nearly all cases, except where we may have had considerable bruising, is aconite. In the latter event, we would, of course, think of arnica.

In conclusion of this necessarily brief and therefore incomplete paper, let me say that in no department of medicine or surgery can more brilliant successes be made than in the prompt and efficient management of these cases, and, on the other hand, there can probably be no more disastrous results follow than in these same cases when mismanaged or neglected. It therefore behooves every one, whether in special or general practice, to be able to meet and successfully, or, at least, properly, treat this class of injuries.

GLYCERINE COTTON PLEDGETS IN ATROPHIC RHINITIS.

HORACE F. IVINS, M.D., PHILADELPHIA.

THE object of this paper is to call to your attention to that form of *local* treatment which in my hands has nearly supplanted all other *topical* measures. I do not advocate this treatment to the exclusion of internal medication, but simply as an adjunct to the Homœopathic remedy, the latter being prescribed, when possible, upon general broad indications.

The cotton tampon, as advised by Gottstein, yielded me practically negative results; therefore I decided to attempt improvement. I first moistened the tampons with the various preparations which I had found useful as sprays in atrophic nasal catarrh. The soda solutions gave little better results than the dry cotton tampon. Next were tried the numerous petroleum preparations, and of these fluid albolene proved most valuable.

Feeling that something still more efficacious might be found I tried, among others, that which of all seemed least indicated, namely, glycerine. To my great astonishment and delight this gave such decided and prompt relief that I was tempted to doubt either the remedy or the diagnosis. Forty-eight hours later, however, the old annoyances began to show themselves one by one. This led to a repetition of the treatment and the favorable results.

My reason for not trying the glycerine sooner was that its well-known affinity for water, and its relief to copious discharges and hypertrophic conditions seemed to contraindicate its efficacy in a disease where atrophy prevails and where the discharges are so wanting in fluid as to dry immediately upon exposure to the air. It was with some hesitation, therefore, that I made the venture lest my patient's condition might be aggravated.

The action of the glycerine applied in this manner seems to be that of exciting the sluggish mucous lining to renewed activity, causing it to pour out its secretion in such quantity as to loosen the dried, hardened formations and dissipate the unpleasant odor.

The method of application is very simple, and, at first, can be carried out almost as well by the patient as by the physician. Later, however, more care is needed in placing the pledget. A small quantity of absorbent cotton, nearly large enough to fill the nasal passage, is grasped at one end by a pair of light forceps. The pledget is moistened in pure glycerine, almost to saturation, and is introduced through the nostril well into the lower meatus. In a few minutes the slight smarting sensation, arising directly after the introduction, gives place to a feeling of relief and to a free, watery nasal flow. When the latter is established, rarely requiring more than ten minutes, the nose should be blown vigorously, freeing the cotton. The blowing should be continued as long as any discharge can be forced from the nasal fossæ.

It is scarcely necessary to state that the cotton should be introduced into one nare at a time ; a second piece can be passed into the other as soon as the first passage is entirely cleared. The second side, however, does not always require treatment, as the excitation occasioned in the one is often reflexly transmitted to the other. The application should be made twice a day until marked relief is secured ; then the morning application will prove sufficient. This should be continued for a number of weeks, and less frequent treatment should be continued for a year.

Owing to the irritating effect of pure glycerine upon the nasopharynx the patient should not lie upon his back while the pledget is in position.

In preparing the cotton, packing is to be avoided ; the mass should be left in a loose, fluffy state. Should the watery flow fail to occur, it may be concluded that either the pledget is too small or that too little glycerine has been used. In either case the first piece of cotton should be removed and a second and more suitable one substituted. At first the lower meatus alone need be treated, but afterward the application should be made where the dryness or discharge appears.

It might be thought that the repeated profuse secretion occasioned by the use of glycerine would be followed after a time by an aggravation of the dryness. This I have never seen, nor have I ever observed an unfavorable symptom traceable to the use of glycerine pledgets in atrophic rhinitis.

The symptoms indicating the use of this treatment are a fulness, pain, dryness and burning in the nasal fossæ, offensive odor, frontal headache and often difficult or non-concentrated thought (aprosexia). The relief following the use of the pledget is often so prompt as to make the patient feel that some anæsthetic has been used or that a superhuman power is at work.

Although I have never found any measure at all comparable to it in cases in which the preceding symptoms were present, I do not consider the use of cotton glycerine pledgets as infallible curers of atrophic rhinitis.

DISCUSSION.

Dr. H. W. Fulton thought that he would use in these cases a medicated spray of vaseline to modify the symptoms. It was, however, his habit to send them to a specialist.

Dr. M. R. Jamison has been in the habit of using pure glycerine on lamb's wool tampons. A much larger surface can be reached in this way.

Dr. E. C. Parsons has used Merrill's preparation of hydrastis in glycerine, diluted with water. This he applies on cotton to the walls of the pharynx, and has the patient snuff it up his nose.

BUREAU OF PÆDOLOGY.

The Homœopathic Medication of Children—Its Influence on the Health of the Race, by C. A. Yocum, M.D.
The Treatment of Prolapsus Ani in Children, by E. E. Briggs, M.D.
Clinical Cases, with Remarks, by W. G. Dietz, M.D.
A Case of Epilepsy, by Charles Gangloff, M.D.
Hindrances to the Cure of Children's Diseases, by A. P. Bowie, M.D.
The Effects of Errors in Eating Upon the Health of Children, by W. J. Martin, M.D.

THE HOMŒOPATHIC MEDICATION OF CHILDREN —ITS INFLUENCE ON THE HEALTH OF THE RACE.

C. A. YOCUM, M.D., POTTSTOWN.

When I decided to write this article I was reminded that probably nothing new or interesting could be said on the subject, and consequently I shall endeavor not to treat the subject in a comprehensive way, but merely reiterate and attempt to impress upon the Homœopathic mind and conscience what may already have been said on the subject, and submit for your consideration a few wandering thoughts, with the hope that my labor may not be entirely in vain.

The medication of the human body was probably intended by the Great Architect, at least it has always been deemed necessary by man, and dates back as far as the history of the race. It has been practiced in all ages and by all people and tribes, from the most barbarous up to the highest type of civilized man, and the methods and remedies used have often been as varied, cruel, and hurtful (and often more so) than the diseases for which they were prescribed.

If any one should doubt this statement, it is only necessary to

take a careful retrospect of the history of medicine, and to any rational mind it will be clearly evident that whatever the motive of physicians in the different periods of medical practice may have been, their methods frequently were most cruel, ignorant, and barbarous, and generally guided by anything but common sense, to say nothing about their knowledge of the human system, the remedies, or the diseases for which they were prescribed.

They seemed to be entirely oblivious of the fact that the human body when diseased was never intended to be a receptacle for all the poisons, as well as the harmless substances found in the material world, and worse than that, prescribed without any why or wherefore, without any definite law of cure, merely a blind experiment, and that at the expense and peril of the unfortunate and helpless sufferers. They knew not that the human system was recuperative in its nature, that if the laws of health are known and observed, it has a tendency to repair, and by its inherent power and a little assistance would be ultimately restored to perfect health.

This gloom and ignorance was not dispelled until the immortal Hahnemann proclaimed to the world *similia similibus curantur*, and gave to suffering, diseased humanity, the law of cure, by which they might be speedily cured, gently and permanently relieved of their disease in its entire extent, in the shortest, most reliable and safest manner, according to clearly intelligible reasons (*Organon*, sec. 2).

But to return to my subject. I will now endeavor to mention a few thoughts in regard to the Homœopathic treatment of children and its influence on the health of the race. And first, I shall notice, what is the Homœopathic medication of a patient? and what does it involve?

a. What is its status as a curative agent?

b. What advantage does it afford the doctor and patient over other systems of medical practice?

c. What are the difficulties, if any?

d. And in what respect is it superior to any other known method of treatment for the prevention, alleviation, and cure of disease?

And secondly. What is its influence on the health of the race?

These are pertinent questions, and certainly of great interest to

the profession and laity. And I shall now attempt to answer them according to the best of my ability—which will probably be in a homely, brief, and imperfect way.

The medication of children, especially infants, has always been one of the chief bulwarks in the defense, success and spread of Homœopathic truth and practice.

Very many people, and among them some Allopathic physicians who don't believe in Homœopathy, acknowledge that it is good enough for children. What an acknowledgement! For if it is scientific and curative enough to reach the case of a child which, without doubt is the most difficult to treat, it certainly is sufficient for adult cases and all cases.

It is when the only child, perhaps a darling babe, is languishing and wasting from the effects of some dread disease, and also from the more blasting effects of some powerful drug or depressant, whose only action is deathward, after all hope seems to have disappeared, when the regular strokes his beard, looks very wise and says: "Its only a question of time," as a last resort the despised Homœopathist is called in (just as the Lord is called upon when men reach their extremity), and by the application of similia restores the child to health.

It is here as nowhere else that the careful, observant, intelligent Homœopathist has the grandest opportunity to test and demonstrate the efficacy of the well-selected similia, and convince the parents, guardians and all concerned beyond the peradventure of a doubt, that there is healing power in the similar drug, the single remedy and the minimum dose. And were it not for the blinding darkness of ignorance, the prejudice, arrogance and oppression of the *irregular school*, and the almost unchangeable power of long-continued, established custom, why, to-day, the ruling overwhelming therapeutics of the civilized world, instead of being empiricism, two-thirds of which might justly be denominated malpractice, would be scientific, curative therapeutics according to the law of *Similia Similibus Curantur*.

What is Homœopathic medication of a patient, I will observe it is not the careless, ignorant prescribing which is practiced by some who call themselves Homœopathists, who have studied medicine in a way, have graduated from medical colleges and

have diplomas, but are anything but physicians; who will prescribe a remedy with but little regard for its Homœopathicity, forgetting that they are dealing with human life, and caring but little whether their patient recovers or not, only so they receive their fee, and if they notice no immediate improvement from their careless prescribing, will resort to any or all of the quack medicines and depressants of the Allopathic school, and then if they lose their patient will ease their conscience with the belief that the Lord took the patient out of the world.

Homœopathic medication is the careful selection and administration of the indicated remedy, after having made a most careful and thorough examination of the patient, and if possible concluded definitely as to the diagnosis, with due attention given to diet, nursing and the general surroundings of the patient.

We, no doubt, often lose our patients, not because the proper remedy has not been applied, but for the reason that the *little things*, which in the aggregate always count, have been neglected or overlooked by doctor and nurse. The indicated remedy is not always a drug. I pity the doctor whose only remedies consist in the administration of material substances. It sometimes is wholesome advice, combined with the careful administration of placebo; it may be a change of climate or occupation, a greater or less amount of exercise, or a different kind, a crucifixion of some bodily or mental habit, etc.

I remember, on a certain occasion, being hurriedly summoned to see a woman, who I was informed, had been afflicted with nightly attacks for some time, and was dying. I made as much haste as possible, and upon entering the room, found its dimensions about 10 by 12, without any door or window open during the hot month of August, and was occupied by a man and his wife and three small children as a sleeping apartment. The woman, who weighed about 200 pounds, was the victim, and had been under treatment for heart disease without any relief. I immediately opened the door and window, and prescribed the indicated remedy, which was pure oxygen, and the patient had no more nightly attacks of heart disease.

No, it requires that a doctor should be a careful, constant student, a close observer, should keep a record of cases, should en-

deavor to have a thorough knowledge of his profession, should avail himself of every possible opportunity to increase his stock of knowledge, and never forget that he is dealing with lives.

Its Status as a Therapeutic Agent.

I wish to say briefly that it stands unchallenged and unchallengeable by every one who has taken the time and trouble to study it, and who comprehends its laws and principles, except those whose prejudices make them the enemies and opposers of truth.

It stands pre-eminently above and beyond any and every mode or system of medication that has as yet been given to man; and the future presages for it a glory and triumph which will doubtless surpass the expectations of its most ardent admirers and most hopeful prophets.

I now wish to notice some of the difficulties which stand in opposition to the speedy, gentle and permanent restoration of the infantile health, for there are not a few involved, for the Homœopathic medication of a patient does not always result in a speedy and satisfactory cure, although many of the laity seem to think that after a tender infant has been mutilated, its nervous system nullified, and its stomach and bowels well nigh destroyed by disease and the usual ruinous compounds of the regular school; then they seem to think that it only requires a few doses of the medicine in which they haven't a particle of confidence to restore the dying child to perfect health. And if their flimsy theories were practicable, death would soon be robbed of its terrors, and the Great Creator be compelled either to leave his creatures here forever or else translate them all alive, like Enos or Elijah.

Probably one of the greatest difficulties is to make a correct diagnosis and secure the totality of the symptoms, for as a rule in small children we can only elicit objective symptoms, and must prescribe from these and what we can learn from the mother or nurse, for the attempt to secure subjective symptoms from an infant, has been compared to looking for the time of day when the clock dial is destitute of hands.

I shall now notice the Homœopathic medication of children in relation to its influence on the health of the race. And first, I

will say that its influence begins with the initiation of the child into the world, consequently is advantageous and far-reaching. It is reconstructive and preservative instead of destructive, in that it modifies any existing tendencies or pre-existing dyscrasias which may be inherited, and which threatens destruction, incapacity, weakness and imbecility to its unfortunate possessor.

It stands second in point of benefit and importance to the human race.

The advent of Hahnemann's law of cure seems to be significant, for it came into the world a little while after the first grand experiment had been made by the signers of the Declaration of Independence to throw off the monarchial empiricism of imperfect government, and form a government of, for and by the people; it was just before the invention of the steamboat, the locomotive, telegraph, and the numerous other inventions which have blessed and benefited mankind.

It gives the new-born babe a better chance to become a perfect specimen of physical manhood or womanhood, to possess a sound mind in a healthy body, and thereby fulfil the duties and responsibilities of life, to win its victories, enjoy its pleasures, bear its misfortunes, guard against its disasters, and overcome its difficulties.

Its influence brightens the fireside, saves time, money, care and anxiety; mitigates what it cannot entirely eradicate, and helps to entail upon posterity a constitution that is a pleasure instead of a torment and burden to its possessor, and helps to build up a desirable habitation for the transient residence of the immortal nature.

And while Christianity is giving to the world soul-rest, and hope, and republican government is securing just rule among the nations, Homœopathic medication is restoring health, preventing disease, and helping to make this house of clay a suitable habitation for the in-dwelling spirit.

In conclusion let me ask, what should be the qualifications, the character, aim, and purpose of the Homœopathic or any physician—the individual who certainly is the instrument in the hands of God in helping to secure the redemption of man's physical nature from the wreck, tendency and consequences of disease?

And what should be the attitude of the State toward the Homœopathic profession? Should it not, at least, afford them fair play, support and representation in every institution whose aim and purpose is the healing of mind and body, and the betterment of the human race?

TREATMENT OF PROLAPSUS ANI.

E. E. BRIGGS, M.D., PITTSBURGH.

THE first thing to be done when called upon to see a case of prolapsus ani is to reduce the prolapsus, and to accomplish this with ease and little pain should be our greatest desire.

The above results will usually be accomplished most readily, especially in young children, in the following manner: First anoint the protruding bowel with any oily substance which may be at hand and then have some one present invert the child by taking hold of the lower extremities, then by exerting very slight taxis upon the protruding bowel you will usually cause it to slip back through the anus.

There may be exceptions taken to this position in the treatment of such cases. It may be stated that it is unnecessary to completely invert the child to reduce the prolapsus. This we will admit, but experience has led me to believe that nothing will aid you so much in the reduction of the prolapsus and give as good after-results as the complete inversion.

The rationale and advantages of this procedure certainly are very plain. By inverting the child the abdominal and sacral contents tend to gravitate toward the thoracic cavity, and by so doing it not only very materially assists in, but really gives, a more complete reduction of the prolapsus, and afterwards it will be less liable to re-prolapse. It has been my pleasure to see one case of prolapsus which was habitual with almost every stool completetely relieved and never returned after the one reduction. This may have been a mere coincidence, but can be left for discussion.

In some cases we meet with such severe contraction of the

sphincter ani and muscular fibres of the rectum that it is rather hard to reduce the prolapsus. If you are unfortunate enough to meet a case of this kind, which occurs frequently, use the following ointment locally both before and after reduction: Fluid extract of hydrastis, 1 drachm, vaseline, 2 ounces.

In passing, it may be well to state that my attention was first called to this action of hydrastis, in relieving contractions and spasms, several years since when treating a severe case of strictures of the rectum by gradual dilatation. It was my custom to anoint the bougies with vaseline or sweet oil, but on one occasion not having either at hand I was compelled to use some hydrastis ointment. To both the patient's and my delight I found the introduction much easier and less painful. This symptom has been verified many times since.

Having reduced the prolapsus, the next question that arises is, how will we prevent the recurrence of a prolapsus? It will be most effectually and rapidly done by using external combined with internal treatment.

Externally the use of various ointments will prove very efficient. The hydrastis ointment will prove very satisfactory when you have the severe contractions before mentioned, and in addition there is more or less ulceration and fissures about the anus. Balsam of Peru will also meet many cases of the same character. Pinus canadensis has proven very satisfactory where there is considerable inflammation and oozing from the protruding bowel.

Where there is a general lax condition of the muscular fibres of the rectum and sphincter you will invariably find splendid results by the daily application of the following: Acidi tannici 1–2 drachms, vaseline 2 ounces. For internal medication we must select remedies which cover the constitutional as well as the local symptoms. A few of the most important remedies with their characteristics, which have been clinically verified, are the following: Hydrastis Canadensis is especially indicated where there is a general catarrhal condition of the alimentary canal, and also more or less jaundice. The stools are either mixed or covered with mucus; and there is considerable inflammation and ulceration attended with great pain, tenderness and contractive feeling about the rectum.

Ignatia is indicated in nervous children where the child sobs long after the prolapsus has been reduced. The prolapsus takes place during stool and is followed by great tenesmus and constriction making it rather hard to return the bowel.

Mercurius solubilis has most violent tenesmus and continued urging. Cold sweat on forehead. The prolapsus usually follows an attack of dysentery. The protruding bowel is very much engorged and is accompanied more or less by oozing of blood.

Mercurius corrosivus would be indicated where the same symptoms are present, especially when accompanied by tenesmus vesicæ. In very young children it is hard to note the latter symptom.

Nux vomica has violent urging and straining, and instead of a stool has prolapsus.

Podophyllum has prolapsus during and after stool, with comparatively slight straining or pain following.

Sulphur will nearly always give valuable service, when you find, in addition to its general symptoms, the child falls asleep immediately after reducing the prolapsus.

Having had slight experience with other remedies it will no doubt be better to wait for verifications in the future before writing more on the subject.

CLINICAL CASES, WITH REMARKS.

W. G. DIETZ, M.D., HAZLETON.

Case I.—Pneumonia. On May 22d of the present year I was summoned to see a little girl, said to be dying with pneumonia, and who thus far had received no medical attention, a younger child having just died with similar symptoms and without having been seen by a physician.

On my arrival at the bedside of the wretched little sufferer, I learned that the child was taken sick with measles about two weeks before. The latter disease appeared to have run a normal course, but, being allowed to run around out of doors without

sufficient clothing, the weather being wet and cold, before she had fully recovered, she was taken with a chill about eight or ten days ago (exact data are wanting), the chill being followed by high fever, severe pains in the chest and almost constant harrassing cough. Although the symptoms persisted in varying intensity up to the time I was called, nothing had been done for the child, except the administration of teas and other household measures to produce diaphoresis and catharsis.

Status quo.—Greatly emaciated; face pale, with circumscribed redness of the cheeks; sunken eyes; the cough harsh, dry and painful, each paroxysm giving rise to painful contraction of the features; tongue dry, covered with a dirty, grayish-white fur, except at the tip; sordes on the teeth; breath hot and offensive. There was complete loss of appetite, the child refusing everything offered except water, which it would drink in large quantities, only to be vomited up from time to time. Three or four diarrhœic stools daily; urine very dark, scanty; chlorides absent; no albumin. The skin was dry and harsh. There was great restlessness complained of, with constant moaning, and worse at night.

The physical signs were: Temperature (in the axilla), 104.2° F.; pulse, 154, small, quick; respirations, 70; panting. There was dulness on percussion, complete over the whole left lung, both in front and behind; less intense over the lower lobe of right lung, the upper pectoral region of that side still retaining its resonance. On auscultation, bronchial respiration, with fine, crackling sounds, were distinctly audible over the whole of the left lung: on the right side, crackling sounds intermixed with coarser bronchial râles, were confined to the base, whistling and sibilant râles being heard over the upper lobe. The heart-sounds were rather muffled and indistinct; those of the pulmonary artery could not be isolated.

In view of these conditions and the wretched surroundings of the patient, I gave an unfavorable prognosis. I ordered milk-punch and meat broths for nourishment, and prescribed ferrum phosphoricum 6x in water.

On May 23d the conditions were about the same. The patient spent a very restless night. Continued treatment.

May 24th, no better. Temperature, 104.2° F., pulse 165; respiration, 76. Dulness on percussion extending upward. The patient refuses all nourishment; wants nothing but water. I prescribed sulphur 44m, three doses, three hours apart and placebo.

May 25th, slight improvement. Cough less constant, and evidently less painful. Temperature, 102.6° F.; pulse, 148, and of better quality; respiration, 62. Some slight perspiration on the hands and face is observable. The dulness over the right lung has not progressed, and occasionally a coarse râle is heard over the upper lobe of the left lung. The mother tells me that she is generally worse from 4 P.M., and as I noticed, or thought I noticed, a wing-like motion of the alæ nasi, I was induced to prescribe lycopodium 30.

May 26th, not so well; more restless again; the cough again was more troublesome and the few indications of its becoming more loose had again given way to complete dryness. Temperature, 103.0° F.; pulse, 150; respiration, 62. The patient received phosphorus 3x in water.

May 27th, no change. Continued treatment.

May 28th, still the same; very restless after midnight; drinks very often, but only a little at a time. Prescribed arsenicum 3x.

May 29th, evidently losing ground; I could not take temperature on account of the great restlessness of the patient; pulse, 160–165, difficult to count; respiration, 76. The case seems hopeless.

I made another effort to obtain data upon which to base a prescription. I learned that the child had eczema of the face two years ago, which had been cured (?) with external remedies, and that it had never been well since. The eruption had always been made worse by being washed. This bit of history, with the dry, coated tongue, very red at its tip, induced me to again prescribe sulphur 44m, three doses.

May 30th, looks better; less restless; cough a little more loose, yet does not raise anything; slept several times, about fifteen minutes at a time. Temperature, 102.8° F.; pulse, 144; respiration, 62. Received placebo.

May 31, better; cough looser; very little pain; had several

hours sleep during the night; tongue shows moisture along edges and tip; took some nourishment; mucous râles over whole left lung; dulness less marked on the left side; about the same on the right. Continued placebo and as much nourishment as child will take.

June 2d, great improvement; expectorates large quantities of muco-purulent matter, occasionally blood-streaked; dulness of left lung, rapidly disappearing; less marked on right side. Temperature, 100° F.; pulse, 178; respiration, 32.

From this time improvement continued uninterruptedly without the further administration of any remedy, but a liberal supply of nourishment and improvement in the surroundings of the patient.

Remarks.—There can be no doubt that the administration of lycopodium on the day following that of sulphur was a great mistake and spoiled the case, as the latter remedy would have done then what it had to do at last, if left undisturbed in its action.

Case II.—Pneumonia. G. K., a little Italian boy, had measles two weeks before, but had been pronounced well by his Allopathic physician and had joined his playmates on the street. About a week before being called he had a chill, followed by high fever, shortness of breath and severe cough. These symptoms persisted to a variable extent up to time of my first visit, when the patient presented the following conditions: Considerable shortness of breath; temperature, 102.2° F.; pulse, 94, rather small and weak; respiration, 42; coughs a great deal, rattling on the chest, but does not raise anything; had raised some blood in the beginning of the present illness. According to the statement of the parents there is no perceptible fever in the morning; but about 3 P.M. the cheeks would commence to become flushed and the skin would become burning hot; this would last until about 12 P.M. (saw patient about 6 P.M.); tongue coated; anorexia; bowels move loosely seven or eight times a day.

Physical examination shows flatness on percussion over the whole right lung, from above downward, less marked at the base, with crepitant râles and tubular breathing; coarse bronchial râles on the left side. I prescribed sulphur 44m, three doses. I saw

patient again on the second day following, at 6 P.M. Improvement in all respects. Temperature, normal; respiration, 26; pulse, 80; the cough much less loose; expectoration yellowish, thick; tongue almost clean; wants to eat.

Physical examination, reveals complete disappearance of dulness; some mucous râles persisting on the right side. Has slept all of last night.

The patient being so much improved, the parents deemed further attendance unnecessary, especially as they lived quite a distance out of town. I have made inquiry since, and learn that the boy was well and out of doors in a very short time.

Remark.—May not the dulness on percussion in this case, disappearing as it did inside of forty-eight hours, be in part at least due to thickened bronchial secretions, instead of consisting entirely of a fibrinous exudate?

CASE III.—Chorea. M. N., a girl aged eleven years, a descendant of an highly neurotic family on the mother's side, the father being very healthy. About three years ago, she was knocked down and terribly frightened by a vicious epileptic youth. This was followed by great nervous agitation, but, owing to serious illness and consequent death of a member of the family, was not taken much account of until some time after, when distinct choreic movements were showing themselves. It was about this time that the patient was first brought to my notice, and presented the usual symptoms of a case of chorea. Deeming the fright the exciting cause of the illness, I prescribed ignatia. Although persisted in for some time, and given in high and low potencies, the case progressed from bad to worse day by day. The spasmodic movements were general, but always worse on the left side and ceased during sleep, which, however, was broken, and the face assumed an idiotic expression. I now prescribed strammonium and advised a visit to friends, hoping that a change in surroundings would be instrumental in bringing about a change for the better. After an absence of four weeks, she was brought home again, the disease having meanwhile progressed and reached a degree which it was painful to behold. It was now about three months since she received the shock which caused her illness; she had lost control of all the voluntary muscles of her body; she

was not able to stand or even sit. If placed upon a chair, she would be thrown forcibly to the floor; her bed was made on the floor; the walls were padded with pillows to avoid self-injury during her violent movements, which, although lessened in violence, no longer ceased during the short snatches of sleep she was able to obtain. She would frequently bite her tongue, and her appearance was that of profound imbecility. She rarely spoke, and when she did, the words were jerked out in monosyllables. The urine and stool were often passed involuntarily and the general nutrition of the body was far below par. Swallowing was difficult, owing to the ataxic movements of the muscles of deglutition. Particles of food would frequently enter the larynx and give rise to distressing paroxysms of coughing, and, on several occasions, spasm of the glottis. I was sorely perplexed as to what to do, and the outlook certainly was a gloomy one. The inability to take a sufficient amount of food, and the incessant movements, could not fail to bring about a fatal result, unless relief should come soon. I now, on account of the extreme violence of the movements, prescribed cicuta 30 in water every two hours, and in twenty-four hours there was a change for the better. The improvement continued uninterruptedly, and in about five or six weeks all irregular movements had ceased entirely, except an occasional twitching of the limbs. Gradually, with increasing strength, she regained the use of her limbs, and the imbecile expression of her face gave way to one which showed that reason was again established. The spine, however, remained sensitive and the left arm weak.

A year later, she never being in good general health, again had a severe fright, by being chased by the same epileptic, which was shortly followed by a return of the choreic movements. Notwithstanding the administration of aconite and apis to counteract the effects of the fright, and of ignatia and strammonium, the disease did not lessen, but again became more and more severe. Again I gave cicuta, and it too, failed to show any marked beneficial effects. I omitted all drugs for a few days, when I administered sulphur 44m, three doses, in the course of twenty-four hours, which, while it did not influence the choreic movements, seemed to improve the general condition of the patient. This I followed again with

cicuta, which was immediately followed by improvement and in about four or five weeks, my little patient was about as well again as she was before her last attack. About two months ago, she had measles, which ran a mild course, and since then she has had some occasional jerking of limbs accompanied by nervous irritability. She complains especially of sensitiveness of the spine and a paretic weakness of the left arm; she is very sensitive to mechanical impressions, and is now taking agaricus.

Remarks.—Although cicuta, which rendered such eminent service in this case, was prescribed on account of the violence of the spasmodic movements, it probably helped by its beneficial effects over spasms the result of mechanical injuries to the nerve centres. Not knowing the violence of the blow inflicted until a late period, it was but natural to ascribe the whole illness to the fright alone.

DISCUSSION.

Dr. J. C. Burgher said it had been his experience that in these conditions all paroxysms cease during sleep, and in all cases of chorea all motion ceases during sleep.

Dr. Bowie cited a case occurring in his practice in which the child made more motions during sleep than at other times. There were also motions while sitting and standing, but, beyond the regular motions of the body, none whatever while walking. There, is, in this case, a rheumatic history, and this fact, together with the aggravation while at rest, led him to give rhus toxicodendron, which remedy she is (the patient) now taking.

A CASE OF EPILEPSY.

CHARLES GANGLOFF, M.D., PITTSBURGH.

Harry M., æt. ten years, of a very nervous temperament, sustained, September 29, 1889, in my stable, a compound fracture of skull, the result of a kick from a horse. Happening to be at home just at the time, I carried him to my office, where he recovered consciousness in a short time.

On examination, I detected a clean, profusely bleeding gash across the frontal eminence, extending one and one-fourth inches on each side of the median line. The scalp was firmly adherent below, sloping upwards, but loosened above from the pericranium to the extent of one inch. The raising of that flap exposed a depressed fracture of the outer table, in the same direction horizontally and of about the same length as the outside wound, but, on account of the sloping, one-fourth inch higher, the upper fragment being depressed about one-thirty-second of an inch, leaving a small groove. The pericranium, cut across the seat of the fracture, remained intact below, but was loosened of its adhesions above and shrivelled up to the extent of one-half inch, leaving the skull exposed.

After having all hæmorrhage stopped by compression, the wound well cleansed with calendula solution and the ends of the pericranium brought in close approximation, I dusted the groove caused by the depressed fracture with iodoform and closed the wound with four sutures, covered it with iodoform gauze and absorbent cotton and gave arnica 3x internally. On September 30th the child was seen in consultation with Drs. W. J. Martin and C. A. Wilson. No abnormal symptom, except a fever of 102° F. and an irregular pulse ranging from 108 to 120. We removed one of the middle sutures in order to give vent to a little oozing, and prescribed aconite 3x. Two hours afterwards the fever abated, to return again in the evening, when it reached 103° F. The next middle stitch was then removed and aconite 3x continued, and the wound dressed and kept moist with cold compresses of 1 per cent. to 60 per cent. of carbolic acid solution.

October 1st.—Patient passed a good night, without least complaint. At 7 o'clock A.M. the temperature commenced to rise, reaching 103° F. at 11 A.M., when seen by Drs. L. H. Willard and C. A. Wilson, the child being, aside from the fever, as bright as ever, without any complaint of headache. The wound discharged very little and the pus was laudable. The stitches were all removed, and aconite 3x with chininum arsenicosum 3x alternately were prescribed.

October 2d.—The child was seen in consultation with Dr. C. A. Wilson. He had passed a good night, and no pain had been

complained of. There had been no rise of the temperature since the afternoon of the previous day, and whatever small quantity of pus there was it had a most laudable appearance, the wound looking well also. The carbolized compresses were kept up, and chininum arsenicosum 3x given internally.

October 3d, 4th and 5th.—During these days the fever assumed an irregular, intermittent character, staying a few hours and then leaving altogether, reaching sometimes 104½° F., yet the child never complained of headache. A consultation was held with Drs. L. H. Willard, W. J. Martin, and J. H. McClelland. The operation of trephining was thought of, yet postponed until October 6th, in case the temperature should rise until then. We continued carbolized compresses and prescribed aconite and chininum arsenicosum 3x alternately every hour.

Was that irregular fever of a malarial origin or due to septic infection or to some internal lesion of the coverings of the brain? This was, at that time, a very difficult question to decide.

That same evening, namely October 5th, I had another consultation with Drs. J. H. McClelland and L. H. Willard, by which it was decided to have the wound completely opened and perfectly irrigated with a 1 to 2000 solution of bichloride of mercury, and afterwards to blow into it pure iodoform. From that time on there was no increase of temperature, and rapid convalescence followed. The depression left after the wound was completely closed amounted to one-sixteenth of an inch.

The remittent fever was undoubtedly set up by absorption of pus, however small in quantity, through the small bony groove above mentioned, and absorption prevented by antisepsic treatment. From that time on the child was as before, very bright, active, and nervous. He kept entirely well until last Christmas evening, *i.e.*, fifteen months after the accident, when, about 9 P.M., after he had received his Christmas presents, he was seized with a light attack of convulsions, affecting his face and upper extremities, lasting but a few seconds. I prescribed aconite 30x, followed two days after by one dose of ignatia 2c. February 15th last, after some excitement he had a second attack, more severe, during his first sleep. Prescribed aconite 30x, and followed two days after by silica 30x, night and morning. April 9th he had the third

attack, and from that time on the fits came on oftener and were of a more severe character, always during his first sleep, and preceded by an aura the child could not describe. Aconite, arnica, ignatia, silicia, etc., were given in vain.

On August 3d last the child had a most severe attack, lasting not less than four minutes, during which he became entirely cyanosed and bathed in cold, clammy sweat. Having investigated in our numerous journals the question of trephining for traumatic epilepsy, we were convinced that the operation would be justifiable, even if nothing would be found to explain the alarming symptoms. I put the child under the care of Dr. J. H. McClelland, who corroborated my opinion.

On August 7th the operation was performed under strict antiseptic measures by Dr. J. H. McClelland, assisted by Drs. L. H. Willard, W. J. Martin, C. A. Wilson, J. E. Miller, myself and C. L. Gangloff. The child being anæsthetized, an oval incision was made above the border of the scalp, the flap carefully dissected and drawn over the old cicatrix, the pericranium severed as much as required, and the trephine applied close to but on the right side of the median line, in order to avoid injuring the superior longitudinal sinus. On the removal of the disc of bone the dura mater appeared absolutely normal; no adhesions had formed. Beside a slight depression upon the membrane the button showed a depression of the outer table with compression of the diplœ. Both tables were fractured.

The wound was closed by means of silk and silver sutures, having been first dusted with iodoform, some gauze applied and the whole covered with absorbent cotton and bandaged. The child recovered nicely from the operation, never showing a trace of fever afterward or complaining of pain, and was seemingly well. On the fourth day I removed the dressing, but as the wound appeared healthy, I reapplied the same dressing immediately. On the seventh day I removed all the stitches, the wound having healed by first intention. In order to prevent any bulging of the membranes of the brain slight compression was kept up for a month afterwards by means of a pad of cotton and a bandage. Since the operation the boy is apparently in perfect health; he feels and looks better than before, and is increasing in weight. He has had no attack of epilepsy since.

Though the time is too short to pronounce him completely cured, he has so far been greatly benefited by the operation, and the cure likely will prove permanent. I will take pleasure in reporting at our next State meeting.

DISCUSSION.

Dr. Willard, who assisted in the operation, considered it justifiable, but from the present state of his information concerning the case he could not say what the result would be. He believes that in gunshot wounds of this description operation was certainly justifiable. The majority of such cases die anyway, and should have the advantages of any possible benefit which might be derived from operation.

HINDRANCES TO THE CURE OF THE DISEASES OF CHILDREN.

A. P. BOWIE, M.D., UNIONTOWN.

Mortuary statistics show that a large portion of the infant population live but a few years, and many have a much shorter existence. This startling fact must ever engage our attention until some means can be devised to change this order of things, and we can do no better than study thoroughly the subject of pædology in all its aspects.

While it is true that for sick children, as well as adults, the properly selected Homœopathic remedy is the best way of administering drugs for the cure of disease, it does not constitute all of the treatment they should receive at our hands; for there are many agencies besides drugs that contribute to our success, and we should see that they are supplied, for without them our best selected remedy will not act.

One of the first lessons taught me when commencing the study of medicine was that it was the physician's duty to place his patient in the best possible condition for recovery, and now, after

more than twenty years' experience, the importance of this teaching is more apparent than ever.

I have selected as my subject hindrances to the cure of the diseases of children, and will endeavor to show why we fail to cure some of the children placed in our care, for it is very gratifying to know that in some instances there are no obstacles placed in our path, and thus the physician is placed at an advantage, but in other cases there seems no chance for a cure when we survey the situation and see the obstacles to be overcome; but one way to learn to do a thing is to know the hindrances placed in our way that we may try to remove or avoid them.

The skillful pilot, to give us smooth sailing, must know all the shoals and quicksands that our voyage may be safe, and the doctor needs to know or find out all about the environment of his patient that recovery may be the result of his efforts. How often do we say to ourselves we fear the result on account of not being able to control the patient, or to have our instructions fully carried out.

Of course, while this is true of children when sick, it is equally so of adults, but looking upon children as the most helpless of our patients and the ones who have the least to say regarding themselves, the physician must be on guard and keep eyes and ears open, and use his nose as well, that he may discern not only the symptoms of his little patient, but he should endeavor to reach the cause or causes and do all in his power to regulate the surroundings that they may be conducive to recovery. What a pitiful sight is a sick child! How helpless it is! How appealingly it looks into our eyes! And what tortures it had to endure before the advent of Homœopathy—very often the treatment was worse than the disease. As a fit text for my subject I can do no better than quote a case treated by Hahnemann and so brilliantly described by a French author, and republished in the *Hahnemannian Monthly* for January, 1891.

"How did Hahnemann act in this celebrated case? He went straight to the cradle—threw a piercing glance at the child—listened to the details of the disease without taking his eyes from her. Then his face suddenly flushed, the veins of his forehead swelled, and he called in an angry tone: 'Throw all these drugs

out of the window; all those vials that I see there. Take the cradle out of this chamber—change the sheets and pillows and give her all the water she will drink. They have kindled a fire in her; we must first put it out, then we will see.'

"We observed that the changed temperature and linen might be dangerous. He replied impatiently, 'That which is killing her is this atmosphere, these drugs. Take her to the *salon*. I will come again this evening, and above all, water! water! water!'"

How well does this describe scenes in our own practice, where the first thing to be done is to remove hurtful things from the child that nature may not be thwarted and our remedies be allowed to act. It seems to me that too little stress is laid upon these all-important little points, and too much time is given to the selection of the proper remedy, or rather the case should first be placed in a proper condition for recovery and then let our attention be directed to the remedy. In this model case of Hahnemann it was several days before the indicated remedy was administered.

Hygiene must ever be the hand-maid of medicine, and more attention should be given to its study if we wish the best results from our treatment.

It will be impossible to mention all the obstacles met with in practice, and our paper will aim to be suggestive rather than exhaustive.

We all acknowledge the fact that children are our most susceptible patients—either good or evil effects them most, and thus diseases attack them that adults have outgrown.

One important hindrance to their cure is previous Allopathic drugging.

The baneful effects of crude drug medication was never more prominently brought to my notice than when treating a case of *morbus coxarius* several years ago, where a number of frightful abscesses had formed around the hip-joint, and which no doubt were caused by calomel given to cure whooping cough. The physician who gave the drug said it would either "kill or cure."

The hereditary effects of drugging are often seen in children, and many cases of scrofulosis are caused in this way.

Improper diet is another hindrance and should be regulated in each case that we are called upon to treat.

I find many children that are overfed and a like number that are underfed, and this condition must be corrected in each case.

Careless nursing is another baneful influence that we most often see, and must correct if success is to crown our efforts.

The child's sick room is another thing we often find hindering recovery, and whenever in our power we should make such changes as are necessary.

Recently in treating a child with gastric fever, I found the boy was brought down stairs every day in a cool, damp room, "to cool the fever" as the mother said, but which interfered with recovery, in my opinion, and which I corrected to the help of my patient.

I often think that too much stress has been laid upon heat being the cause of summer complaints of children, and children are kept too cool, and many a case of diarrhœa and enteritis is due more to the effects of cold than heat, and improper clothing in summer will very much interfere with our success in curing summer ailments, and should be corrected.

Many more points might be mentioned in this connection but to call attention to the subject and arouse discussion is the object of my paper, and I hope the members will respond that we may learn of each other, for it has been truly said that "freedom of discussion is essential to the development of truth."

DISCUSSION.

Dr. Dietz believes that the majority of cases of intestinal troubles, even during the summer, are caused by chilling; that the excess of heat is rather a minor cause. In his practice, he always orders, even during the summer the continuance of the warm bandage and stockings, and advising care that the dresses may not be too long. He believes that many cases could be improved if more attention was paid to the matter of having the body properly covered.

SOME OF THE EVIL EFFECTS OF ERRORS IN EATING UPON THE HEALTH OF CHILDREN.

W. J. MARTIN, M.D., PITTSBURGH.

My experience and observation in fifteen years of pretty active practice, a large portion of which has been among children, leads me to believe, that aside from the acute infectious diseases and constitutional diseases, errors of diet are accountable for more sickness among children than all other causes combined. I do not include the sickness of infancy, for childhood, as we understand it, is the state from infancy to puberty.

Concerning the feeding of infants much has been written, and people of ordinary intelligence are to some extent informed thereon ; but, concerning the feeding of children, little (so far as I know) has been written, and the people generally do not seem to have the remotest idea that there is a right and a wrong way of feeding their children, and yet I believe it cannot be successfully denied that in consequence of the almost universal wrong feeding of children, nearly all their sickness results, except that from the two sets of causes mentioned, and this is especially true of children brought up in cities. By errors of diet I mean the eating of improper kinds of food, the eating of improper quantities and the eating at improper times. Among small children the improper kinds of food most frequently indulged in are candies and pastry, and sometimes meat to excess. Fresh meat in proper quantities is beneficial, candies and pastry in almost any quantity are injurious, and yet with very many children there is scarcely an hour of the day that they are not eating candies or cakes, and at meal times they do not care for plain wholesome bread and butter and vegetables, and the more candies and cakes they eat the less of wholesome food they want. These are the children for whom we are so frequently called upon to give "something for an appetite." This incessant eating of sweetmeats so universally indulged in by the children in cities, besides destroy-

ing the appetite for plain nourishing food that would build up the body and make the child strong, produces abnormal thirst for water, and the water in some cities of this Commonwealth is not a very desirable beverage, though good water is good for all children. I have frequently observed that those children who habitually "wet the bed" are of the class who eat much candy and drink much water, and our efforts to cure such will fail until a stop is put to the candy eating. A case in point is that of a girl of five years whom I had treated for over a year for enuresis without the least effect; she would soak the bed every night. The child was sent to the country this summer where there were no candy shops and the sugar bowl was placed beyond her reach; she quit drinking so much water and also quit wetting the bed.

What a vast multitude of children is being doctored, either by parents or physicians, for "worms," not one of whom would be sick if they had eaten the proper food in proper quantities and at proper times. How often do we see small children with a large section of Bologna sausage or smoked sausage in their fists gnawing away, more like dogs than human beings. These children bye and bye will be taken to the doctor to "see if they don't need some medicine for worms." Or you may be summoned in haste by an excited messenger to "come quick; the child is working in spasms," as the following case occurring while preparing this paper well illustrates: A young lady called one afternoon requesting me to make a visit to her aunt's child, which they feared would soon die. I called as requested and found a little girl about two years old in violent convulsions which had lasted then about twelve hours with no intermission or abatement. The history of the case was that the previous day, the child being perfectly well, was taken by the mother to the city, where they visited several stores, the child receiving some cakes and fruit and lastly some smoked sausage from the kind-hearted storekeepers, all of which she ate. That night, somewhere between midnight and daylight, the child awoke feverish and vomited violently, the ejecta consisting largely of sausage, and at once went into these violent convulsions. A physician in the neighborhood was summoned immediately, but his efforts at relieving the child having failed I was solicited to take charge. Fortunately under the influence of cicuta the spasms

abated and the child finally recovered perfect health, but there was very nearly another innocent life sacrificed through ignorance.

The eating of pickles and condiments, now so extensively indulged in by young people, especially young girls, is doing inestimable damage to the health of the rising generation. Almost any day can be seen groups of girls on their way to school each eating at a large pickle. Pickles are an indispensable requisite to the lunch of the school-girl and shop-girl, and on the table pickles, catsup, chow chow, Chili sauce and a great variety of sour and hot concoctions known as condiments. Is it any wonder that so many young girls have St. Vitus' dance or become chlorotic and never develop properly into a healthy womanhood? How could they when the digestive system, the nervous system and the whole being has been deteriorated from infancy up by candies, pastries, pickles and condiments. I have known of many cases of girls who eat catsup on potatoes, catsup or Chili sauce on bread and butter, and at lunch eat nothing but crackers and pickles. When these girls get old enough, or have an opportunity whether old enough or not, they marry, and then the progeny, what is it? We are all familiar with the history that is repeating itself every year. The young mother has no milk, or not enough of milk, or her milk is "no good," then comes the nursing bottle, the trying of the thousand and one kinds of prepared foods for babies, to be had of all first-class druggists, besides the condensed milk, the milk from one cow, the goat's milk, etc., etc., in the vain effort to get a food to agree with the baby. The doctor is consulted, maybe many doctors, and in spite of all that can be done, in a very large per cent. of these cases, the scene closes by the entrance of the undertaker, and the young mother has contributed another to that innumerable multitude of which it has been said: "If they were so soon to be done for, what were they begun for?"

How striking is the contrast between the children and young people we meet in our cities and the country-bred children; and more striking yet is the contrast with the children of European peasants coming to this country. Their strong frames, well-rounded bodies, ruddy cheeks, bright eyes and good humor command our admiration. They are the children of a class who receive but sufficient remuneration for their labor to enable them to

procure the necessities in the way of food and clothing, none of the luxuries. Therefore these healthy children. Well it is that they come to this country, for these children, and the children of these children are an important factor in giving to this nation sufficient bone and sinew to preserve its prosperity.

The vital importance of the proper feeding of our children should receive more attention. The matter should be brought to the notice of parents on all occasions, in season and out of season. While much has been said, and truly said, of the baneful effects of the consumption of the products of the distillery and the brewery, I have yet to hear of any one raising his voice against the baneful effects of the consumption of the products of the pickle and condiment factory. And while the charge has been made times without number, that at the present day the rum-shop is the greatest curse to mankind, I think we might with about equal truth say that at the present day in all towns and cities of this country the candy-shop is the greatest curse to child-kind.

The following, bearing on the subject under consideration, though not in relation to children, I quote from one with whose name every medical man is familiar, Sir Henry Thompson: "I have come to the conclusion that more than half of the disease which embitters the middle and latter part of life is due to avoidable errors in diet, and that more mischief in the form of actual disease, of impaired vigor, and of shortened life, accrues to mankind in England and throughout central Europe from erroneous habits of eating than from the habitual use of alcoholic drink, considerable as I know that evil to be."

We hear from time to time of children suffering and dying from want of sufficient to eat. In a land of plenty like ours this should not be so; but does it require any stretch of the imagination to believe that in this land of plenty there are by far more children who are suffering and dying because of eating too much. For a number of years I have been the medical attendant to an orphan asylum, where there are at all times from thirty to forty children, and there is scarcely a family that I attend but has more sickness among its children each year than there is in this institution in the same time, and this is due almost entirely to the fact that the children in the asylum are properly fed, or nearly so.

DISCUSSION.

Dr. H. S. Phillips endorsed the ideas of the author, saying that he had met with cases which exemplified the truth of his statements. It stands to reason that if a child is permitted to eat between meals, it will have no desire for eating at the proper time. It must be made a matter of education among the people. They should be taught that nature's plan is to have nourishment supplied the body at regular intervals, and these intervals should be so arranged that the stomach may have a proper period of rest.

BUREAU OF SANITARY SCIENCE.

Climatic Maxims for Invalids, by B. W. James, M.D.
The Sanitation of Body-Temperature, by J. C. Morgan, M.D.
Alimentation, by J. C. Burgher, M.D.
How to Best Take Care of Milk, by C. Van Artsdalen, M.D.

SUGGESTIONS FOR INVALIDS IN NEW CLIMATES.

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It is well known that many catarrhal, bronchial, pulmonary and asthmatic cases go to places called health resorts, simply on the general reputation of the place, without obtaining, or regardless of, medical advice, and spend considerable money and time in residing at or visiting improperly selected places, to the injury of the individual or non-benefit of the symptoms they are seeking to relieve.

To all seekers of health in new climates I kindly offer the following:

1. Your physician or medical climatologist should thoroughly diagnose and prognose your individual case and then prescribe the general climatic conditions required and the probable localities that meet the requirements of your case and also point out any dangers you may be subjected to at one or another of these locations as far as he is able to ascertain.

The questions of temperament and your susceptibility to cold or warm weather, your dietetic rules and the kind of food obtainable, the evenness of temperature, freedom from excessive moisture, or sudden change, etc., should be taken into account in the recommendation.

Some members of the profession, who have not studied climatology, are fair enough to their patients who need a climatic change

to send such cases to a specialist familiar with the subject for a candid opinion as to the best place to be selected for restoration or benefit at least; but the majority of invalids in the beginning of their disease are in the habit of loosely selecting for themselves some resort with which they have not fully familiarized themselves as to its adaptability to their case, or they spend valuable time in travelling about hunting an agreeable spot.

Climate is like any other adjuvant or remedy, and should be carefully selected with a view to the best results. Having ascertained that the case is one in the *first* stages of pulmonary phthisis and that the home-climate is of such a character as to aggravate the symptoms and cause the disease to run on into the second or later or incurable stages, my first suggestion is that the case go away *at once* to a suitable climate where proper remedies can also be applied, and where the patient can have a good home in case a permanent residence is absolutely necessary, and that the invalid should heed the recommendations and not delay going until the disease has thoroughly matured to its second stage or has even advanced to the third or incurable stage of the malady.

Physicians should always diagnose their cases *early* and send them in the prodromal or early stage to the proper climate and location that will aid in their restoration to health; for climate is not necessarily a remedial agent. It only places the person in the best position and with the best possible surroundings, for Nature to throw off the diseased conditions. Hence the necessity of proper medicinal agents to bring about the cure. A physician should fit out his patient with a few remedies adapted to his case, and also to the special symptoms to which he is subject, and write out full directions as to how they are to be taken, and the dietetic regulations and hygienic treatment he is to maintain.

2. Such cases should have the benefit of sound advice as to what they are to do when they have arrived in a proper climate. Should such locality not prove beneficial in a reasonable time the invalid should maintain a frequent correspondence with his home physician, that he may know whether or not the climate is the one in which he ought to continue his residence. If not, the family physician should write and advise him where else to go and so continue until the suitable one has been obtained,

and not allow the patient to go wandering around from place to place on his own responsibility.

In other words, a physician should not give up his care of his case, and furthermore, he should advise him as to what Homœopathic physician he should call upon in case of a sudden emergency, such as an attack of some acute malady, and the family physician should write to such local physician to show him that he still has an interest in his patient and will expect to continue his care of the case after the acute attack is over.

Thousands of cases are lost to Eastern physicians by neglecting this measure, as their cases fall into the hands of unknown physicians who prejudice susceptible people against the advice of the physician who sent them away for their health. An air of mystery is frequently thrown around the subject of special climates by some such members of the profession, and cases are told that the home-physician does not understand the requirements of the case.

This is all wrong, and I suggest that the family physician should maintain the care of his case unless during the absence it has by some misadventure advanced and the disease has reached the later stage, when probably permanent treatment by a local physician may become necessary.

3. Cases of tuberculosis with the disease fully developed or in the last stages ought never to leave home, and there are various reasons for this sound advice, a principal one being that a pulmonary patient requires a great deal of care and comfort which can only be properly had by a good home, with kind friends and relatives, to nurse and care for them; for if the patient is away in a boarding house or a hotel at some distant resort he is without the same comfort with which he would be surrounded at home. The disadvantage is also much greater and the loneliness less endurable in a foreign country, with a foreign language to contend with.

When a case has reached the incurable stage, it is the physician's bounden duty to honestly tell the case of its exact condition and certain probability of its non-recovery. Such a case should be influenced to make itself as comfortable as possible during the few months it is likely to live.

Many cases are sent to Colorado, California, Texas, or to the

North or West, or to distant lands, that should never leave home, for they are a burden to themselves and their family, as they soon become so greatly aggravated they are unable to be removed home.

Then again in view of a fatal issue resulting at so great a distance from their home and caretakers, great trouble and expense is incurred. All such cases should have the advice given them not to leave home at all. A "home temperate climate" should be artificially made within the patient's own house by the exclusion of great cold or inclement weather. Persons of moderate circumstances who desire to avail themselves of every possible means toward a cure may be greatly burdened by being sent from home when their cases are hopeless ones, and instead of any help being received, the fatigue of travelling, the fret and worry of economizing in such a way as to live within the little means they may have at command, becomes and remains a source of anxiety which of itself aggravates the case and takes away any little benefit that climate may have rendered in effecting a temporary relief, even for some of the symptoms.

4. Our fourth suggestion is that no patient should be sent to a distant health resort without a suitable companion accompanying them and to remain with them during the climate treatment; for many invalids have not been accustomed to travelling or visiting away from home among strangers, and these should not be sent, when they are quite sick, into strange places without a suitable person to help care for them, converse with them, and cheer them up and watch over them. Besides they will become lonely and will doubtless be imposed upon in various ways by unscrupulous people who will take advantage of their helpless condition, and by people who make it a study to thus ingratiate themselves and then impose upon the timid and inexperienced who have been sent to climatic resorts by physicians who do not understand the peculiarities of the invalid traveller, or the surroundings by which he or she will be environed at "Health Stations," as they are termed.

5. Invalids having been sent away should remember that they are to keep themselves cheerful and be out in the *open air* as much as possible. This latter measure involves taking along a supply of clothing for both summer and winter weather, for sudden cold

changes and electrical disturbances are liable to occur even in the warmest climates, and patients must avoid the painful influences of these sudden changes and yet be in the sunshine and out in the open air as much as possible during the daytime. They must not depend upon spending a great portion of time in reading, as this would be too much of a tax upon their nervous system and vision, and keep them too much confined to the house, and yet they are not to be entirely idle and lazy, as that will allow them to brood over their own condition of ill health ; they should as soon as they ascertain that a climate agrees with them get at some light work which will not employ all their time but give them a little maintenance for themselves, and above all keep the mind from their sufferings. A small plot of land on which they can maintain a garden or raise floral plants by their own labor is a good method. They should not mingle with consumptives nor with persons who are constantly talking of people whom they know that had the same disease, or gossippers who relate every fatal case they ever heard of.

They should have plenty of sunlight, cheerful friends around them, good diet, frequent baths, pleasant amusements, and daily moderate exercise in the out-door air.

They should not be travelling from place to place, hunting out new resorts, but should give the selection of the home physician a fair and perfect trial.

Their dress must be maintained suitable to the climatic surroundings. The appetite must be encouraged by such articles of nutritious food as they enjoy and can take.

A good appetite can be encouraged and maintained by regularity of meals and a suitable kind of diet.

Late hours, stimulants, and excesses of every kind must be persistently and continually avoided.

THE SANITATION OF BODY-TEMPERATURE.

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ONE might suppose, from the elaborate study already given to body-temperature in various special diseases, that there remains but little, if anything, yet to be learned. However, we as yet know only in a meagre way that which underlies all this, viz.: the variable body-temperatures to be found in so-called states of health. Almost the only observations above the commonplace are those adduced by Wagner (*General Pathology*, pages 605 to 608).

To begin with, all scientific requirements combine to fasten our attention upon this fundamental proposition, viz.: that all disease, and thus the whole science of pathology, is in perpetual parallel with health; is, in the last analysis, nothing more than a plus or minus of the normal; or, a combination of the two in divers directions.

This statement needs a counter-statement, or rather, a corollary, to complete it, viz.: all states of health, so-called, present resemblances to those of known disease. Temperature variations, plus and minus, with all their concomitant signs, are, then, facts of health, within due limits. To these our most careful study is due, as a basis for all else.

Repeated observation in my own person has shown that, in ordinary health, body-temperature varies much from the accepted standard, 98.4° F. The weather has some influence upon this; also clothing, and, particularly, food and exercise. In general, the body-heat rises slightly after a meal. Psychic energy seems to be often a cause, sometimes an effect, or at least a concomitant, of such rise. Nervous stimulation has a like effect.

The German observations indicate a regular ebb and flow of temperature in a healthy adult; the lowest being at about 1.30 A.M., with a secondary depression occurring at 11.30 A.M., and the highest at 5.30 P.M., with a secondary rise at about 7.30 A.M. This daily variation justifies the assertion that normal life is,

after all, only a type of intermittent fever, and that the phrase "life's fitful fever" has a real and profound physiological, not a mere poetic, value.

Now, as body-temperature is the measure of current physiological conditions, whether normal or abnormal, the *concomitants* of fever, in its various stages, plus and minus, must be assumed, along with this fall and rise. The phrase "normal fever," therefore, is no solecism. In apparent health, then, a slight variation may well be taken as significant of concomitant error in other directions, and by this rule "symptoms" will less often seem "imaginary" and "illusory." I have recently noticed a fall of one-half degree as a whole day's warning, and also as a concomitant to the moderate pains of a dynamic dysmenorrhœa. In chronic diseases, any similar minus or a plus, is an important and characteristic symptom, and may well challenge recognition in selecting the remedy. Bœnninghausen's monograph on Intermittent Fever is just as valuable, therefore, in the study of other diseases and their remedies, as of this. Not only is this true, but it is also imperative, in all drug-provings, to note all symptoms of this class.

Sleeping, waking, eating, exertion of mind and body, all are no doubt potent factors in determining the "normal fever" symptoms. Indeed, the reversion of habits in certain professions or employments is distinctly asserted to be a sufficient cause of a reversion of the above typical orders, as day sleeping with night working, etc. I must, however, believe that the revolution of the earth, with the presence and absence of the sun's rays, is the most important of all factors, not only as the producer of external temperature changes, and the direct agent of body-heat, but also as an alternating, tidal, periodical, dynamic, physiological irritant. *Abnormal* fever, then, presents only an exggeration of the normal, *in all particulars.* There can be little doubt that other celestial bodies, at longer intervals, have a positive action in periodicity, not yet duly studied, either in health, in disease, or in drug-provings, yet of momentous import.

In normal infancy and early childhood, according to Wagner, the *rectal* temperature averages about 99.7° F. In adults he gives the following: *axillary* temperature, at about 1.30 A.M., 97.7° F.;

at about 5.30 P.M., 99.6° F. (nearly two degrees of rise); at about 11.30 A.M., "some tenths (of Centigrade) lower, say, 98° F. These figures are substantially corroborated in America by my own experience when in robust health.

Summer weather and a tropical climate promote high body-temperature, and marching in the hot sun often raises it far beyond the normal, with a subsequent abnormal fall during the cool night, the normal periodicity prevailing with myalgia. *Gelsemium* is Homœopathic to this. If the muscular suffering be more extreme, *chininum sulphuricum* is the simile. Other drugs, however, may better suit other symptoms—if marked—of course. A simple feeling of *intolerable* dry heat demands *chamomilla.*

Late suppers and the usual breakfast alike tend to a rise, with strong, hot coffee or tea, especially; alcohol, in *large* doses, to a fall, which, read Homœopathically, between the lines, means a rise from *small* doses. A warm bath causes a moderate rise; a short cold bath, with undressing and dressing in a cool room, in a vigorous person, is followed by a very slight rise, reminding one of the Hydropathic treatment of chills by a cold plunge, a really Homœopathic measure. Short, intensely cold bathing, or a longer cool immersion, or *exposure,* lowers the body-heat—this last being a matter of great surgical importance. Ether in excess has the same effect; in a recent case down to 97° F. Small doses, therefore, are curative in like case. Abundant cold drinks lower it as much as 1.8° F. Such lowering may develop chill, internal venous congestion and cramps. In this is involved a general principle, as I have convinced myself, viz.: that there is a close relationship between *chill* and convulsive movements, or crampy, as well as shivering and shuddering conditions (apart from that rare form of convulsion seen in connection with hyperpyrexia, as in the death agony in some cases of sunstroke, of tetanus, etc.). I repeat that in ordinary cases clonic *spasm* is a representative of *chill.*

At the onset of scarlatina in little children this is a well-known experience. Another anomaly, however, must not be overlooked here, viz.: that in intermittent fever, with forenoon paroxysm, the temperature, several hours before the apparent chill, as well as during this, has been found high—even at 104° F. This estimate

is somewhat checked by the question, What drugs had the patient been taking? The subject needs further investigation.

In *sepsis* the surgeon takes warning, above all, from a rise of temperature, which is his signal to open, disinfect, drain and re-dress his amputation or other wound.

Congestive chill, hemorrhage, collapse of any kind, is marked by a sharp fall of body-heat.

Insanity is ordinarily and typically associated with low temperature, as well as poor nutrition. I have observed the effect of this last, in atrophic conditions of the finger-nails, the line of demarkation being very distinct at the convalescent point. Temperature is, then, a strong point in remedial selection.

Idiosyncrasies exist, as to body-heat, as with everything else in the physiology of the body, and in some cases, as of injury of the spine, etc., the records, apart from the credit due to the character of the individual observers, would seem fabulous. The authority of Mr. Teale and the London *Lancet* may be quoted for an endurance of weeks, with final recovery, in such a case of a temperature of 122° F. On the other hand, a woman lying drunk and exposed through a winter night recovered after showing a (vaginal) temperature of but 79° F. Minor idiosyncrasies may also be met with. A sudden fall is sometimes a presage of hæmorrhage, a sudden rise is equally under suspicion of paralysis. In senile states, even if existing at forty to fifty years of age, even a slight elevation is therefore to be considered important.

Women and all irritable persons show relatively higher normal grades, whilst in sickness, they suffer greater fluctuations, than others. Convalescence in general may be attended with both rise and fall. Chronic diseases are likewise variable, according to the irritable or quiescent conditions present, hence, "fever symptoms," plus and minus, are "characteristic indications, as already set forth."

Temperatures below 96° F. are dangerously subnormal, and "hyperpyrexia," with its perils, exists at above 106° F. Both are of the nature of collapse of life's power. Both, in Old School practice, according to Prof. H. C. Wood, indicate moschus, as a remedy. Camphora, and other drugs, however, may be chosen by their characteristics, in our school.

The *sanitation* of body temperature relates largely to posture, to clothing, bed-clothing, bed-rooms and other apartments, and to the use of water, hot, cold, or tepid, and of ice. Not only in health, but still more in sickness, and in surgical practice, is the practitioner required to study and apply it.

1. *Posture.*—This may be associated with other factors, as clothing, bed-clothes, etc. Inactivity of the body and mind and recumbent posture, tend to reduce heat; but a special experience repeatedly occurring to Prof. J. M. DaCosta, and by him reported in the *American Journal of the Medical Sciences*, some twenty years ago, and showing the contrary effect of recumbency, is that of "post-typhoid high temperature." The prolonged stay of the convalescent in bed, so necessary to safety in some cases, may in others be productive of persistent high temperature, even after all other symptoms have subsided. No medicine seems to control it, but getting out of bed or even sitting up in bed, is followed by establishment of the normal. In a recent consultation with Dr. T. C. Imes, of this city I had the opportunity to fully verify this. A young woman who had entered upon apparent convalescence from a typhoid state, continued to show a body-heat of 101° F., at evening and above 99° in the morning. I advised that she be directed to sit up in bed, which was done; and thenceforth her progress was uninterrupted, the temperature falling to normal at once. Per contra, in low grades of body-heat, it is well to go to bed and cover warmly.

2. *Clothing.*—This is largely determined by personal feelings and often mistakenly. Linen is a better conductor of heat than cotton—"cooler," to use a common expression. Woollen flannel, whilst not a good heat-conductor, may be practically cooler than either by absorbing and promoting evaporation of hot sweat. Personal experience in the tropics enables me to recommend the wearing of a porous, light woollen undershirt, and unlined flannel outer clothing under such circumstances. The access of wind to the body is also thus favored.

Just here, there is a danger to be guarded against. The illustration is furnished by the simultaneous experience of two missionaries on a journey in Africa. Halting at noon, one threw himself coatless, upon the ground, under the shade of a tree, and rapidly

became cool. The other buttoned up his coat to exclude the too strong breeze then blowing, and walked slowly to and fro, *gradually* reducing his heat. Both continued to do the same and similar things. The result was that the latter maintained good health, whilst the former died of African fever, within a few weeks. In like manner, the cool night air of our own August, after a scorching day determines, according to my observations, internal venous congestions, of liver, spleen, stomach, bowels, etc., and serious diseases thereof; also the endemic fevers, and the so-called "malarial cachexia." In our Gulf States, a damp coldness at night, following intense heat by day is common, and severe endemic diseases result even in virulent forms. Chronic internal scurvy also appears. *Fires* in the open air, sufficient woollen clothing keeping the skin and mucous membranes equably comfortable, with a well sustained nutrition, are the effective "anti-malarial" agents. Fasting, indigestible food, alcohol in excess, fatigue, and depressing emotions, whatever, in short, tends to lower vitality, aggravates the effect of temperature error.

Winter clothing, rooms, fires, ventilation, are so universally studied as to require little mention here. Sudden changes, as at other times, are hurtful. Extremes of cold produce congestions, inflammations, etc. Exposure of the upper extremities affects the chest, especially in little children. Equally the lower limbs concern the abdominal organs. *Absolute comfort* is the best guarantee of safety. Again, the occiput, the nape of the neck, and the spine in general require special care, as these are closely related to the vaso-motor and trophic, cardiac and respiratory centres.

3. *Bed-clothing.*—Again, the feelings of the individual may be exclusively consulted with undesirable results, yet these cannot be ignored with impunity. Still oftener, the mere *notions* of an untrained nurse, or even doctor, may be the guiding force; or sheer ignorance may chance to govern this important element. The lying-in room is frequently the theatre of such errors. The debility of confinement is often the direct outcome of the fear of "catching cold," which causes the victim to be covered to excess, and thus kept in a sweat. Of course, the opposite mistake may also be made; the feet, body or breasts being unduly exposed to cold air, producing febrile and inflammatory troubles. The new-

born child may suffer collapse, lying in a cold room also. Especially is such mismanagement, in common life, injurious, after overheating, sweating, etc. Extremes and violent fluctuations should be avoided at all times.

Many persons habitually lie with the arms and chest uncovered. Little children are prone to do so. A woollen sack, with long sleeves, light or heavy, as required, is "the very thing" for such subjects. Exposure of the feet during sleep or otherwise, causes bowel troubles; and a cold seat tends to dysentery; cold, wet feet to uterine disorders.

The most surprising errors, however, are common in high fever. I have known an intelligent young physician to cover a patient whose temperature was nearly 106° F., with a heavy blanket, and, worse, a quilt; and it is quite usual to find patients in a high fever, upon whom their friends have imposed such burdens. It is scarcely necessary to remark that the effect is often very bad. The "hot treatment" of eruptive fevers in particular, is not wholly discarded, even yet, but it should be, at once, and forever, except in cases of *algid collapse.*

The skin, in fevers should be protected from draughts by a sheet, only, or at most, adding a *light* cotton spread, if desired by the patient.

4. *Bedrooms and Other Apartments.*—The temperature which experience indicates as best for the sick, and for the well who nurse them, in the majority of cases, is the range between 68 and 72° F. A thermometer should, in every case of prolonged illness, be kept hanging in the room, not exposed either to hot or to cold air-currents. In robust health, a lower temperature is well enough, but delicate persons and little children must be guarded against coldness. Above all, a bustling worker must not be permitted to fix the standard for such by her own flushed condition and feelings. Living rooms, as well as bedrooms, should be under the constant test of a thermometer, ventilation going hand-in-hand therewith. Business rooms, also, are capable of doing great injury when the temperature is faulty. A violent attack of jaundice, with catarrahal hepatitis, has ensued from sitting in one's cold office, writing at night, with the lower limbs cold to the knees. Basement rooms are notoriously rheumatic. On the

other hand, a woman who had worked at ironing all day, in a hot close kitchen, in summer, has succumbed at night to the apoplectic type of "heat stroke." In hyper-malarial regions, congestive fevers occur in those whose environment affords no protection against extremes of fluctuation, as to temperature. Negro slaves, sleeping upon a brick hearth; soldiers, in presence of the enemy, obliged to sleep upon the cold ground, without camp-fires; these were, during our civil war, my actual and not very rare examples of these bad results of prolonged exposure to low temperature; and in this category, I have found the worst and most insidious and fatal effect from the range between 33 and 45° F. at night. A lower temperature compels attention and remedy, but this range attracts little notice, and less of remedy, and does a deadly work. Malignant "malaria" flourishes in such nights, particularly if the days are continuously of the *same type;* or if they are on the other hand, extremely hot, venous congestion becomes intense and persistent. Thus, in the Gulf States, there are winter cases and types of congestive diseases, as well as those of summer. The former type, if chronic, constitutes the army "scurvy."

Fatal results have occurred under my observation, from neglect or inability to control the heat of rooms during sickness. Once, a middle-aged woman, with a fever, succumbed to the high temperature of her apartment, which was under the roof of a south back building, exposed to the burning August sun. Again, an infant, likewise kept under a hot roof, whilst a kitchen range added its quota of the excess, fell a victim to the same. It was sick, ostensibly, of summer complaint. The predominance of this disease is on the hottest days also.

On the other hand, a woman who had been under treatment for ulcer of the leg, in the late and inclement autumn, forbidding exposure; yet, in spite of injunctions, she was allowed to remain alone without a fire. Meantime, a diarrhœa had set in, and she rose repeatedly, in her night-dress to stool; likewise keeping her windows partially open, for ventilation. She became cold, rapid hydrothorax followed, and she died of apnœa on the same afternoon. *China* had been taken; and this drug has in other cases, also, seemed to favor such a catastrophe. The death is sudden.

In all such cases of excessively faulty temperature of rooms, and unprotected skin, great solicitude is in place.

5. *Water, etc.*, sanitation of body-temperature. Ice, cold water, tepid water, hot water (and other liquids) are capable of large service, in this way; and may be applied according to a variety of methods. Thus, as to *ice*—including iced water, ice cream, water ices and the like, are well known means of reducing temperature, and are the common palliatives of hot weather, as well as of fever, etc. The too sudden cooling of the stomach by their uncontrolled use is the main thing to be on guard against in their employment. In abdominal inflammations excess is common but perilous; the body-heat being but little elevated, at best, is unfavorably affected thereby in high degree.

In sunstroke, the application of ice, or cold water, to the head —vertex, temples, mastoid regions, etc., is of first-rate value. In hyperpyrexia, it deserves more specific attention than it has received, and should be tested in the way just mentioned.

The common over-heating of summer days may be delightfully subdued in like manner; moderately cold water being quite sufficient. The "pulses" are also telling localities for cold applications, viz.: the wrists, the axillæ, the bends of the arms, the like regions in the lower limbs, and the neck.

There is a special use of *ice in collapse* of the cold type, viz., its application to the *spine*. It is a repugnant remedy to "common sense," because it is so vividly and violently "similar;" yet, for that reason, deserves attention and trial, and there is clinical evidence in its favor. Recently a child in a neighboring town was pronounced dead of cholera infantum. The mother laid it upon a table upon some broken ice and sent for an undertaker, who, on attempting to lift it, was startled by its uttering a lusty cry. The collapse had been relieved by the dorsal ice application. The same agent would probably be more approved in the collapse of hyperpyrexia, but we cannot give place to the antipathic idea so far as to deny its value in the algid type. It is best explained by the theory of central vaso-motor sedation, with filling of the over-contracted peripheral bloodvessels. Central cold and peripheral hot applications thus work to the same end. The mouth, the rectum, the vagina may all be found suitable

localities for the application of ice in divers cases. The hands, also, having wide sympathies, are accessible, and are favorite regions of refrigeration. But it must not be forgotten that thoracic and abdominal inflammations are producible by the chilling of the upper and lower extremities respectively.

Cold water, in the stead of ice, may be applied like it, and more freely. The sponge bath, the plunge bath, etc., are popular.

Sea bathing is often of great use as a tonic and alterative remedy. Literary fatigue, business strain, loss of sleep and many other depressing conditions react under it—a Homœopathic effect. But sometimes the exposure of the body to the cold water, and worse, to the wind whilst standing in it in a wet suit, is not followed by reaction, and then injury is done. The remedy consists in wearing merino or flannel underclothing along with the bathing suit. A strong person may, however, bathe in extremely cold water with luxurious enjoyment by first taking a full plunge, followed at once by running exercise on shore for a few minutes until reaction comes on, when, on re-entering the bath and keeping in active motion, his skin will glow and tingle as if immersed in hot champagne wines or "soda water." After a sea bath some light nourishment, as hot, shaken milk, or crackers and cheese, with repose and protection, aids in securing full, healthy reaction.

A remarkable case of chronic metrorrhagia, twice curetted and injected with iodine, by Sims and Emmett, was at last traced to ice cold sea bathing and permanently cured by *rhus toxicodendron*, followed by *phosphoric acid.*

River and lake bathing, and the city swimming bath, apart from the absence of surf exercise, and of the saline alteratives contained in the ocean, may be spoken of in like manner with sea bathing. The ordinary bath-tub of the home may substitute all these with the multitude and to excellent purpose, particularly for reducing and equalizing the body heat in summer, as well as in high fever.

The "cold pack" is an efficient febrifuge and antiphlogistic. One precaution must ever be carefully observed, viz., to apply, *simultaneously* and frequently, the cold compress to the head, preventing local congestion and sequelæ. After the pack a general cold sponging is required, or better, affusion.

In hyperpyrexia a convenient and *effective* resource is the "half pack." A cot sheet is folded so as to reach from the axillæ to the trochanters, squeezed out of cold water, and wrapped around the body. A single thickness of old flannel over this saves the bed and the patient's clothing from slopping, and also prevents premature drying. Whenever the heat or drying indicates it, this flannel is easily opened and the sheet aired and rewetted. Drugs, as in *all forms of collapse*, in Homœopathic practice are to be used with strict Hahnemannian conservatism.

In the chill of intermittent fever the cold plunge bath, as already mentioned, has often proved palliative, and even curative. The shower bath is a severe shock, but in vigorous persons may be still more powerful in therapeutic effect. On this relation the frequent elevation of the body temperature during the chill stage should be borne in mind.

Cold sponging, or affusion, as just stated, is the proper conclusion to the pack, which, continuing one hour, leaves the surface hot, perspiring, relaxed. The skin should, after this washing, be gently dried, not rubbed, the thin night shirt put on, and the patient covered with a sheet, nothing more, unless demanded by a dominating internal congestion, or by the feelings of the patient, the room being airy and fresh. A similar proceeding, viz., cool or tepid sponging, is very grateful and useful in all cases of ordinary febrile or other sweating, reducing residual heat and giving a sense of strength, cleanliness and comfort. Applied to one limb or part, at a time, under cover, it always produces excellent results. Again, the principle is illustrated, viz., that *every* heated bath, idiopathic as well as artificial, should conclude with a cold or cool affusion or shower or sponging, according to the patient's ability.

Local packs partake of the nature of poultices, hot or cold. *Irrigation* maintains any given temperature, *not* involving the heat crisis in sweat, as in *all packs*. In such cases local heat or cold is utilized to produce and to maintain a temperature favorable to local nutrition and to tissue and circulatory restoration when required. The subjective feelings of the patient are authoritative in determining the temperature in most cases.

Sitz baths, hot or cold, are useful for their effect upon the *general*

temperature, which should always be considered, as well as their influence on the local temperature and nutrition of the pelvic organs. Irrigation of the uterus, etc., with hot or cold water, whilst sitting in the same is a recognized antiphlogistic method. In inflammation of the bladder or rectum, piles, etc., hot or cold sitz baths are valuable. Sometimes spinal douche is combined with these. Irrigation or flushing of the large bowel has proved widely useful, and a certain secret method of treating chronic diseases of all kinds has been found to consist of this alone, hot water being daily used in large quantity, say one gallon.

Temperature (as well as cleansing), and from this, nervo-muscular, cellular and vascular, stimulation as well as sheer bulk, and hence improved nutrition and activity explain it. Certainly, when, in chronic diseases, the axillary temperature falls it may be taken as an index of general as well as of visceral error of a corresponding nature, and, *a priori*, this prescription may be made with a good prospect of benefit.

Hot water may often be preferred to cold in cases formerly supposed to demand the latter only. Cold water dressings for wounds, cold applications for hæmorrhage, etc., were at the height of surgical orthodoxy some years ago, but nowadays hot water finds a much wider field of use in almost all primary and later procedures; whilst bleeding, surgical and obstetrical, is easily amenable, in many cases, to very hot water.

The test of experience may yet, in like manner, nay, must surely reveal the capability of very hot water, in minimum dosage, to control, homœopathically and dynamically, hyperpyrexia, as well as ordinary fever heat. I would suggest the cautious repetition of teaspoonful doses, with frequent observations of the axillary temperature.

Many persons now positively know that when overheated, *small doses* of very hot water, or tea, will give a more decided and lasting sense of relief and *cure* than ices or cold drinks.

On the other hand, in all heat excess, a *large* hot drink is of very injurious effect, whilst the same is a great *palliative* in cold and depressed states; the more, if it be nutritious, as milk, or nervously stimulating, as beef-tea, toddy, etc. The wagons of the United States Christian Commission, on the field of war, did great

service to humanity in furnishing the wounded and the collapsed with these palliatives—hot coffee, tea, beef-tea, milk, etc. Hot shaken milk is, on the whole, usually the best of these, because distinctly nutritious. (Ice to the spine was not tested).

The surgery of large joints, of the pleura, and, above all, of the peritonæum, no doubt owes much of its present comparative safety to the sanitary and salutary agency of *hot*, pure, and particularly, *distilled* water, recently prepared. The staunching of oozing bloodvessels, otherwise a source of secondary hemorrhage and of septic degeneration, and the preservation of the normal nutritive high temperatures of the cavities preventing shock, are in themselves sufficient reasons for great reduction of mortality. Personal observation has satisfied me that even now fatal results are largely due to neglect on the part of operators to give specific personal care to this matter, trusting too much to assistants. The heat of the water should, for all such purposes, be as high as can be *comfortably* borne by the knuckles of the hand, and care should be given to the proper renewal of the fountain, and to the maintenance of its temperature, and to its steady application to the very end of the operation, as well as to the preservation of the *body-heat*. To this end, that of the operating-room is to be kept at the maximum.

Hot vapor, apart from any medication, has not only a great therapeutic activity, but as well a vast sanitary use. The old Thompsonian sweat-box, the Turkish and the Russian baths, are of extraordinary power to maintain, hygienically, as well as to restore, therapeutically, the equilibrium of the circulation and of all the functions, particularly in those subjects whose reaction is inadequate after cold bathing. In all of these the conclusion by cold affusion, or the cold plunge, or shower, is needed to obviate a prolonged relaxation; also removing effete excretions from the skin. Thus, too, the nutritive standard of body-heat is rapidly established and qualified everywhere, and a general sense of well-being obtains. Feeble women and those persons whose habitual temperature gives warning of the approaching senile minus, if at all able to bear it, are often benefited, as are lithæmic people, whose minus relates mainly to the scavenger functions of elimination. As in municipal service, these are distinctly sanitary,

and the hot vapor method is a valuable means of promoting them. Ordinary hot plunge-baths, especially for those unable to bear the others, followed by cold affusion and rest; and even hot sponge-baths are similar in utility. Hot salt-water baths are invaluable to many. Not only is the hot vapor or hot water a direct sanitation, but the resulting cutaneous activity secures integrity of this, the greatest of all *self*-regulators of the body-heat.

Like the postscript of certain letter writers, let us present here some of the principal of all the factors of heat production and regulation, viz., 1st, *dietetics*, using the term in its widest sense; 2d, *the atmosphere.*

1. In analogy with baths, *cold water as a beverage*, is of the greatest potency, in three ways. First, it renders latent, by its capacity for heat, a large amount of this agent. Second, by its action on the skin, kidneys and lungs, the emunctories, *par excellence*, as well as on the gastro-intestinal mucous membrane, it eliminates that heat directly from the blood and tissues. Third, by this profuse sweat resulting is by the influence of clothing, and of atmospheric humidity, kept in disagreeable contact with the body; and by this as well as by accumulation in the bladder, the final ridding of the organism of its heat being impeded, the resulting discomfort evokes the *voluntary* aid of the individual, and thus the function of heat illumination is completed by bathing, change of clothing, micturition, etc. The effect of *hot* water as a drink has already been discussed.

Food substances proper are well known in the rôle of heat *production*. Their part in heat *regulation* and sanitation is a necessary corollary, but has been less considered. *Beef-tea* and its injurious heat-stimulation when given in typhoid fever, long ago emphasized by Rápou, has been mentioned above. All *indigestible substances* beget dynamic movements, like chill and fever, and should be estimated upon. Alcohol too, with its primary and secondary effects, in varying doses, is to be allowed a place in the account. Starvation is anti-caloric, in the first instance.

However, the interest of this topic is more fundamental. The instincts of mankind, civilized as well as savage, discriminate in favor of heat-sanitation. The Esquimaux not only covers himself with the furry hides of polar animals, themselves clothed in

reference to this object—but he lays in a stock of oil and blubber, on which he feeds with gusto, utterly unaware that these are known to science as calorifacient foods. The Krooman, on the west coast of Africa, agrees with him in the choice of nerve and muscle food, *fish*, but he indulges little in the oily foods, preferring vegtables and fruits, as cassada (or cassava), yams, "greens," with bananas, oranges, sour-sops, cocoanuts, etc. Yet calorifaction is, even to him, a food problem, to some extent. The starchy matter of cassadra and yams, and the sugar and oil fruits, and promiently, palm-oil, are necessary to his support.

The means of *heat elimination* must needs, however, be abundant. The first of these is his *enormous* consumption of nature's beverage, water. In addition, he goes nearly naked—sweats like a sieve, through a supple and satin-like skin; and plunges, at will from land or canoe, into sea or river—to which he is inured from infancy; combining with his dietary all the natural resources for heat reduction and regulation in high degree —an example to civilization.

The delicate lady who scorns "pork," and especially fat pork, partakes but sparingly of butter, and to whom potatoes are repugnant—when subjected to the rigors of a northwestern winter, keenly craves all these things, whilst she may be even vexed with herself for having such base desires. And the vigorous man, in tropic heats of midsummer, can with little sense of privation, and with great additional comfort, dispense with the sugars, starches and fats in general, living mainly upon lean meats and fruits. Clothed warmly, as he often is, water drinking is, whilst wholesome, productive of discomfort, and is disputed.

Natural self-sanitation should be carefully studied with reference to the needs of the sick, who depend upon the physician for the choice of their food. Even in fever the nitrogenous tissue being largely preyed upon by the oxidizing process, a certain amount of hydrocarbon is a necessary dietetic protective to those tissues. This is conveniently supplied, along with other elements of nutrition, in pure milk, which after standing, and thus separating, must be thoroughly shaken up and its parts commingled, in order to obviate errors of digestion. Other foods, well known to all, may be substituted at discretion. Fruits, so prepared as to

be manageable by the debilitated or irritated stomach, are valuable. A ripe pear, for instance, may be scraped out with a silver knife, and the semi-liquid pulp be taken; the inside of baked apple, with shaken milk; the juice of a sweet orange; these are all invaluable in fever; and so is *strained* vegetable soup, or broth; their suitableness to heat-sanitation, as well as to nutrition and tissue-protection, being sustained by their acceptability.

2. *The atmosphere* itself is of the utmost importance in temperature sanitation. Not only its own temperature, but also its barometric and hygrometric states strongly influence heat regulation. A high barometer means a heavy atmosphere, inimical to *evaporation.* A moist atmosphere has the same property. Apart from mere evaporation, however, *density* of the air promotes *conduction* of heat away from the bodily surface. *Radiation,* again, is impaired thereby. Quiescence of the air is unfavorable to both both conduction and evaporation. Motion, on the contrary, as of the winds, promotes both, and so is a favorable reliance for heat-reduction, in warm weather. Fanning is the artificial substitute. The tropical trade-winds are a perennial source of comfort and well being to all living things under their influence. Cold winds are dangerously irritating, often. Draughts of air between doors and windows have a bad effect, partly because the individual occupies one position for a good while, the effect is localized, and his sedentary condition offers no stimulus to the circulation or perspiration, and both are inhibited—tending to internal congestions. To the sick this is perilous, indeed.

ALIMENTATION, RETROSPECTIVE AND PROSPECTIVE.

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MAN is an omnivorous being. To secure and maintain a high standard of physical development and mental vigor he requires a mixed diet. This statement is especially applicable to the inhabitants of the temperate zones, whether civilized or barbarous. Our

bodies are ungergoing constant change. Every movement of the body, every exertion of the voluntary muscles, the involuntary contractions and expansions of the heart and the movements of respiration, and even the acts of talking and thinking, are attended by the disintegration of some portion of our tissues, which must be renovated of effete material in order to receive fresh supplies necessary to maintain their vital activity. This constant waste of tissues makes necessary a corresponding supply of food to make good the loss sustained. Since all the ingredients of the body constantly require to be replaced, they must form a part of the food. Alimentary materials may accordingly be classified into groups, distinguished from each other by certain well-marked characteristics.

1. The first group comprises the inorganic substances proper namely, water and the mineral salts. They are all essentials of the food, since they form an indispensable part of the body. Of the inorganic substances that enter into the composition of the human body, water is the most abundant and most indispensable. It forms from two-thirds to three-fourths of the entire mass of the human body, from which it is constantly discharged by the skin, mucous membranes, lungs and kidneys. The water thus lost must be replaced with the food and drink. An adult man of average size, to supply the wants of the system, requires, on an average, four and one-half pounds of water per day, which is all the better for being pure. Of the mineral salts, which are constituents of the body and of the food, chloride of sodium and the phosphate of lime are important and abundant. They exist in greater or less abundance in all of the solids and fluids of the body. Chloride of sodium is present in the blood in the proportion of four and one-half parts per one thousand in volume; and phosphate of lime exists in the bones and other solid tissues in still greater proportion. Both of these substances are also ingredients of our ordinary food. Chloride of sodium, for example, is found in the muscular tissues in proportion of two parts per one thousand. Herbivorous animals always thrive better when they can obtain a liberal supply of salt, while carnivorous animals find an ample supply in the flesh upon which they live. Vegetarians require a more liberal use of salt with their food than those who use a mixed

diet. Phosphate of lime is a component part of the muscular flesh of animals, fish, oysters, eggs, cereal grains, beans, peas, beets, potatoes, radishes, turnips, etc., as well as many of the juicy fruits. The alkaline salts are also necessary to the nourishment of the body. The blood and most of the healthy secretions have an alkaline reaction, which is due to the presence of the carbonates of soda and potassa. Unlike the mineral salts, however, the alkaline carbonates are not usually introduced into the system under their own form. Many of the fruits and vegetables in common use as food, contain salts of soda and potassa, combined with various organic acids, such as the citrates, malates and tartrates of these bases. These salts are decomposed in the animal body, and their vegetable acids replaced by carbonic acid and become alkaline salts, and provide for the proper constitution of the animal fluids.

2. The second group of alimentary substances comprises starch and sugar. These two substances resemble each other in their chemical constitution, being composed of carbon, oxygen and hydrogen. Starch may be converted into sugar by various methods. Starch is abundant in the cereal grains, in beans, potatoes, peas, etc., and enters in smaller proportion into nearly every article of vegetable food. In the process of cooking starch in contact with water, its grains swell, become softened, absorb water, and finally, if the heat be sufficiently long continued and the supply of water ample, they fuse together into a gelatinous, homogeneous mass. In this state it is much more digestible than in a raw condition, and it is in this form that starch is generally used as food. Sugar is also taken, not only in its pure form, as an addition to other articles of food, but also as a natural ingredient in the sweet juices of most fruits and vegetables. Vegetable substances containing starch and sugar are not only beneficial, as articles of diet, but may be regarded as indispensable for maintaining health in the human species. A diet composed exclusively of animal substances soon becomes exceedingly distasteful, and a strong craving for vegetable food is experienced. Even dried or preserved vegetables will not answer the purpose indefinitely, for there is something in the fresh vegetable juices or substances which is essential to health; and if vegetables are excluded from the food for a long time, symptoms

of scurvy manifest themselves, presenting a generally depraved condition of the nutritive functions.

3. The third group of alimentary substances comprises the oils or fats. Like starch and sugar, they consist of carbon, hydrogen and oxygen as their chemical elements, but the proportions in which the elements are combined are not analagous to those of the former group, and they have also other distinctive characteristics. They are both of animal and vegetable origin, and constitute the greater part of the adipose tissue or fat of animals, twenty-five per cent. of the yolk of eggs, nine per cent. of Indian corn, the whole of the butter obtained from milk, thirty per cent. of olives, and in filberts, walnuts, hicoria, pecans and many other nuts, from fifty to sixty per cent. Fat, in some one or more of these forms, is highly useful and perhaps indispensable as an article of food. The fact that fat constitutes more than three per cent. of human milk, which is generally the first and exclusive food of the infant, proves this to be the case, at least for that age; while the desire which is felt by the healthy appetite for a certain proportion of fat is a significant indication of its importance.

4. The fourth group of alimentary materials comprises the albuminoid substances. This group is distinguished from both the starchy and fatty substances by the fact that they all contain nitrogen. They are sometimes designated as the nitrogenous elements of nutrition, in contradistinction to the others, which are non-nitrogenous. The albumin of egg is, perhaps, the most familiar example of this group of alimentary materials. Musculine, a substance very similar in composition to albumin, forms the principal part of muscular flesh, and is the chief ingredient in lean meat. Caseine is a constituent of milk. Legumine exists in beans and peas, and gluten is the albuminoid ingredient of wheat. It is estimated that an adult consumes rather more than four ounces of albuminoid matters (estimated in their dry state) every twenty-four hours. It has been claimed that the fried fish-balls, brown bread and baked beans of New England contain nearly the right proportions of nutriment required to maintain an adult laborer, in good condition, according to Voit's standard. The pease porridge, seasoned with savory herbs, in which a small slice of pork

is stewed, also furnishes the necessary elements consistent with that standard; as also, the pork and hominy as served out to the negro during his bondage—consisting of one peck of corn meal to three and one-half pounds of bacon for a week's supply.

Repeated experiments show that no single group of the alimentary materials enumerated above is sufficient for the continued nourishment of the body, This is sufficiently evident for the first group, or inorganic substances, such as water and the mineral salts. Vegetables have power of assimilating these matters, and converting them into the ingredients of the vegetable fabric; but animals require for their nourishment materials which are already animal or vegetable in their nature. Even these substances, combined with starch, sugar, or oil, are inefficient. Dumas and Milne-Edwards found that bees fed on pure sugar and water soon ceased to work and finally perished. Magendie found that dogs fed on starch and sugar, or on an exclusive diet of fat, soon became debilitated, and died with symptoms of great disturbance of the nutritive functions. Boussingault fed a duck on butter alone, and although the quantity of this alimentary substance was abundant, the subject of the experiment died of inanition at the the end of three weeks. Post-mortem examination showed that all the tissues of the body were infiltrated with oleaginous material, but this substance had proved incapable of sustaining life. Lehman put himself upon a diet of non-nitrogenous substances, such as starch, sugar, gum and oil, but was only able to continue this course of regimen for two, or at most, three, consecutive days at a time, owing to the disturbance of the general health produced by it. The unfavorable symptoms, however, rapidly disappeared on his resuming an ordinary mixed diet.

The fact that the substances just named are deficient in nitrogen was at one time regarded as a sufficient explanation of inability to sustain life, and the albuminoid or nitrogeneous materials were therefore supposed to be the only absolute and completely nutritious ingredients of the food. Direct experiment, however, proved that these substances, when taken alone, were also insufficient. Magendie fed dogs upon pure fibrine and pure gelatine, and found after some days that the animals lost their relish for food, became emaciated, and finally died with symptoms of inani-

tion. Completely nutritive food must contain not one only, but all the groups of alimentary substances, and these substances must be present in their true proportion. The efforts which have been made from time to time to fix the nutritive value of different kinds of foods by ascertaining their ultimate chemical composition, and particularly by the amount of nitrogen they contain, are absolutely futile. The nutritive value of alimentary substances can only be determined by direct experiment on the living organism; that is by employing them as food, alone and in combination, and observing the results. The nutritious qualities of an article of food depend upon the proportion of its different ingredients, not only as taken alone, but also as employed in combination with other substances. The digestibility and degree to which it conforms to the appetite and natural taste or instinctive desire are also important factors in the problem. Alimentary substances which have been found by universal experience to be the most wholesome and nutritious are those distinguished by the greatest variety of food elements in their composition.

Of all single articles of food for the healthy adult, bread, properly made and baked from unbolted wheat flour, is the most important. Hence the old adage: "Bread is the staff of life." The effect of cooking upon food is twofold. It softens and disintegrates the substances which are naturally too hard in their ripe and dry state for mastication and digestion, and thus renders them amenable to these processes. These effects are produced upon many vegetable substances used for food, such as starch grains wherever they exist, and all food materials having a resisting envelope or a tough and solid texture, such as beans, peas, potatoes, etc.

On the other hand, the most useful effect of cooking animal substances appears to be the partial transformation of the albuminoid matters, as of roasted meat, by which a peculiar and agreeable flavor is given. There are also reasons for the belief that this flavor, besides being pleasant to the palate, is also an indication of a chemical change in the albuminoid matters by which they are prepared for digestion and assimilation and become better fitted to subserve the nutrition of the body, as well as to render innocuous any trichinæ that may be encysted in its muscular fibres.

Prevailing opinions among physicians and physiologists differ

in regard to the use of animal food. It is considered by some not only entirely unnecessary but even prejudicial to health and longevity, while others contend that it is one of the essentials in building up the waste tissues and maintaining their healthful integrity. The advocates of an exclusively vegetable diet may possibly not have taken into account the great variety of constitutions, the law of heredity, climatic influences and the many and varied occupations of mankind. The Alaskan and Esquimaux will consume the blubber of the whale and walrus in quantities that would be destructive to the inhabitants of the tropics; while the bread fruit and banana upon which the aborigines of tropical climates largely subsist would prove equally hazardous to the inhabitants of the regions of eternal snow and ice. And yet the Esquimaux supplements his train oil with moss and sea weeds, while the Alaskan eats the inner bark of the spruce and hemlock, both in the green and dried state, after having been dipped in rancid fish or seal oil, cooled and hardened into a kind of crude and disgusting oleomargarine. The inhabitants of the tropics, in addition to the fruits and vegetables of the climate, also eat eggs and fish when procurable; and the Chinese coolie, whose principal diet consists of boiled rice, as opportunity presents, adds fish and the unsavory flesh of that troublesome and hateful rodent, the ubiquitous rat.

Vegetarians have theoretically constructed a very plausible system of dietetics, but have signally failed to establish its superiority to a mixed diet of animal and vegetable foods. Furthermore it is quite probable that so-called vegetarians, unless of the stricter sort, indulge in more or less animal food in the form of milk, butter, cheese, eggs, etc. While the nutritious elements of vegetables and meat are the same, the latter furnishes them in a condensed form. Cattle, sheep, swine, fowls and other edible animals, which consume large quantities of coarse vegetables unsuited for the human stomach by the processes of digestion and assimilation, convert the gross food into flesh which is wholesome, nutritious and easily digested by the healthy human stomach. A large percentage of the meat eaten might, doubtless, be dispensed with, and nitrogenous foods from the vegetable kingdom, rich in gluten and its congeners, substituted. Those who subsist entirely upon

vegetable food are nourished by the same principles as those who eat meat; but a much larger bulk of vegetable food is required to supply the necessary nutriment than would be requisite for those who eat meat.

But another phase of this subject should not be passed over without a moment's consideration, viz., the influence of a purely vegetable diet on the chalky degeneration of the arteries. Vegetable, being richer in mineral salts than animal food, introduces more of these elements into the blood. Numerous cases of atheroma were observed by Raymond in a monastery of vegetarian friars, amongst others that of the prior, a man about thirty-two years old, whose arteries were already in an advanced state of induration. Treille, a naval surgeon, reports having seen numerous cases of atheromatous degeneration in Bombay and Calcutta, where many of the native inhabitants live exclusively on rice. If it be true that a vegetable diet ruins the bloodvessels and produces premature age, it logically follows that it must also cause at the same time the senile arch of the cornea and be productive of phosphaturia. Alanus says: "Having unfortunately seen these newest results of medical investigation confirmed by my own case, I have, as a matter of course, returned to a mixed diet. I can no longer consider purely vegetable food as the normal diet of man, but only as a curative method, which is of the greatest service in the various morbid states. Some patients may follow this diet for weeks and months, but it is not adapted to everybody's continued use." It is claimed that scarcely more than one-third of the vegetables available for food are generally known to civilized nations, while some of the most valuable ones yet remain to be incorporated with the list of aliments now in more or less general use. The fecula of the arum esculentum would furnish an agreeable variety of food allied to arrowroot and farina, while the bulbs of the camassia esculenta would furnish a better food than the potato. Who has not tired of the limited range and uniform sameness of the food of the family table, alike wearisome to the cook who prepares as to those who partake of it? The diet of most of our boarding schools and seminaries badly needs revision, with many additions. Boarding schools that restrict the fare of their helpless pupils to unwholesome plainness and almost uniform sameness ought themselves to

be forced to quietly die of inanition instead of being encouraged to grind out annually alumni crammed with technical instead of practical knowledge, with health impaired by dyspepsia, languor, headache, brain-fag, hysteria, neurasthenia and the hundred and one other ills, avoidable by varied and nutritious aliment, pure air, physical exercise, innocent recreation and the observance of the well-known, but sadly neglected, laws of hygiene.

MILK AND ITS CARE.

C. VAN ARTSDALEN, M.D., ASHBOURNE.

Milk is an opaque, yellowish-white, sometimes bluish-white fluid, secreted by the mammary glands of the female of the class of mammalia, after they have brought forth their young, and during the period in which their offspring are too immature to live upon ordinary food; it is devoid of odor, except for a very short time after its extraction, has a sweet taste, and is commonly of a slightly alkaline reaction. According to Lamperierre, the daily quantity of milk is dependent upon various conditions, such as food, bodily conditions, etc., yet, as a mean, he has found for each breast the quantity secreted in the course of two hours to be about fifty-five grammes, or eight hundred and thirty grains, making, if the secretion continues at a uniform rate for the twenty-four hours, two pounds and eight ounces for both breasts.

With regular good feeding, the average quantity of milk from the cow for the period of twenty-four hours (by measure) is nine quarts; three gallons of milk, as it comes from the cow, making one pound of butter. In nine gallons of milk there is an average of one gallon of cream, which will produce three pounds of butter.

The composition of the milk of women is somewhat variable. If, for instance, the breasts are emptied frequently, the proportion of caseine is greater, the last portion of the milk contains more fat or butter. Immediately after delivery of the young, the milk is

much richer in fatty matter, and consequently poorer in caseine; there is most salt during the first month, with only a slight decrease thereafter; the sugar is deficient during the first month, gradually rising in quantity until the eighth to the tenth month, when it will be found to be in excess.

In comparing milk of the same animal, the health, food, length of time after parturition, etc., should be considered, as well as when samples of different species of mammalia are compared. The sugar, which is most uniform in its proportions, is materially increased by feeding cows on carrots, beets, or other saccharine food. Certain medicines produce changes in the milk of women; thus, iodine, mercury, and quinine, after having been taken by the mother have been found in the milk.

The milk of women, from fifteen to twenty years of age, contains more solids than that between thirty and forty. Dark-haired women give richer milk than those with light hair.

In making a table of the different constituents of milk, the experiments of Henri Chevallier, Professor Poggiati, and Percy, are presented:

	Water.	Butter.	Sugar.	Caseine.	Salt.
Woman	87.98	3.55	6.50	1.52	0.45
Cow	82.28	4.38	5.27	3.80	0.27
Ass	91.65	0.11	6.08	1.82	0.34
Goat	86.80	3.32	5.28	4.02	0.58
Ewe	85.62	4.20	5.00	4.50	0.68
Mare	93.35	2.02	4.04	0.15	0.24
Bitch	84.00	9.32	2.01	4.35	0.32

It will be noticed by the foregoing table that about three and one-half ($3\frac{1}{2}$) is the actual percentage of fatty matter in healthy human milk, more in cows, and almost trebled in the milk of the bitch; the extractive matter is in about the same proportion.

After milk has been standing, cream forms upon its surface; below is skim-milk. Healthy milk does not coagulate upon boiling, but a film forms on its surface; when it stands for a long or lesser

period, according to circumstances, it sours, due to the conversion of the milk-sugar into lactic acid; the caseine becomes coagulated by the action of the acid, and with the fluid gradually becomes a pulp; later, the curds will separate, leaving a fluid known as whey. The reaction of fresh cow's milk is generally alkaline, and the specific gravity about 1030; skim-milk, about 1040; of human milk, about 1034. Cold milk has a higher specific gravity than warm milk.

As the natural food of the young mammal is the milk of its mother, which contains all the elements necessary for the growth of the animal, combining both animal and vegetable food, it is equally as valuable to the adult as to the child, to the healthy as the invalid.

Referring to the table the greatest proportion of nutritive matter is found in the ewe's milk, the goat's coming next, while the milk of the ass is least nutritive, consequently more easily digested. The ass' milk contains more milk-sugar than the others with one exception, that of the woman. The milk given by the cow after giving birth is unfit for use for several days, being thick, stringy, of a dirty yellowish color. The milk of a cow not in perfect health should never be used. The mother's health when nursing should be watched. In cases where the mother is unable to suckle her baby, we must modify cow's milk so as to resemble that of woman. As cow's milk contains more caseine and less sugar than woman's, gently heat the cow's milk, remove the film, add a little sugar of milk, and we have a very good imitation of the human secretion.

The purity of the milk is of great importance. We will find water is by far the most common adulteration. There are numerous instruments for testing the purity, specific gravity, amount of cream, etc. There is the lactoscope, Feser's hydrometer, creamometer, Heeren's pioscope galactometer, all of which have their special value. Milk may be impure from natural as well as artificial causes. Then the miscroscope affords a good test.

The preservation of milk is of importance. Various methods have been tried for use during sea-voyages. In France they combine different matter with the milk, evaporating the aqueous portion, leaving the residue to the consistency of syrup, then adding

sugar, expelling the air and hermetically sealing while under a steam heat of 100° C.

Condensed milk, named by Gail Borden, Jr., was first made in 1856 in the United States by this process. Take fresh milk, quickly cool to 60° F. Immediately thereafter heat in a vessel surrounded by hot water to 180°, then add refined white sugar one part to nine of milk; is kept in the hot vat about thirty minutes, then is removed to pans and the evaporation of the water is effected at a temperature of 160°. After this it is quickly cooled by passing cold water through the pipes instead of steam. The milk can then be removed to vessels of convenient size and sealed for use.

In preparing essence of milk, a little sugar is added and at a temperature of 110° the fluid is evaporated to one-fourth its bulk. Then it is put in tin cans, soldered tightly, allowed to remain in boiling water for a time, then slowly cooled. It will keep long.

Another preparation, known as solidified milk: To 112 pounds of fresh milk mix 28 pounds white sugar and a little bicarbonate of soda to neutralize the acidity; the mixture is evaporated until it forms a creamy mass, which is compressed into bricks. Mix with warm water when required for use.

Desiccated milk is prepared about the same way, only the evaporation process is continued to that of a dough, then dried, bottled and used as above.

If milk or cream be kept in the same apartment with decaying matter, tainted meat, or kept in vessels that have previously contained any rancid substance, or kept near or exposed to the odor of stables, etc., the liability is to impart to the whole mass of milk a rancid flavor, it having a peculiar affinity for smells of all kinds.

Milk for the baby should be kept by itself in a china or earthen vessel, never in tin; in a cool, clean place out of the dust, never covered over the top, and a small portion heated at a time in a similar or agate ware vessel, used at once. If there be any left throw out, never heat over.

After reading his paper, Dr. Van Artsdalen showed by tests

with the "milch prufer" (pioscope) the relative purity of given samples of milk and cream. He gave an instructive talk concerning the methods for obtaining the specific gravity of milk. He exhibited a lactoscope and illustrated the method of determining the quantity of butter contained in a given sample of milk. Milk, he said, should contain 31 per cent. of fat in order to bring it up to the standard quality. The superintendent of the Pittsburgh Hospital furnished the doctor with samples of milk from the hospital supply, which showed a specific gravity of 1036 and the presence of 4 per cent. of fat. The doctor exhibited a number of milk testing instruments, and gave a description and explanation of the methods and tests used officially in eight of the States east of the Missouri river.

BUREAU OF MATERIA MEDICA AND PROVINGS.

Comparison of Aconite and Bryonia, by J. C. Guernsey, M.D.
Clinical Confirmations, by M. S. Williamson, M.D.
A Brief Study of Aconitum Napellus, by C. S. Middleton, M.D.
The Spider Poisons, by Edward Cranch, M.D.
Kali, by Ella D. Goff, M.D.

COMPARISON OF ACONITE AND BRYONIA.

JOSEPH C. GUERNSEY, M.D., PHILADELPHIA.

Is it ever necessary for a Homœopathic physician to alternate his remedies in treating the sick? As a general rule I do not consider it necessary—and this for several reasons:

1. Giving two or more remedies in rotation, one, two or three hours apart, may injure the case in hand by a union of these multiple drugs in the internal economy, thus producing a new chemical agent of whose action we know nothing.

2. We may retard the cure of a case, or perhaps bungle it beyond the possibility of an ultimate cure, by the internal action of these different drugs proving inimical to each other—each one pulling at the vital force in a different direction.

3. One or more of the drugs, by producing symptoms of its own, may overcome the good done by another remedy at work at the same time.

4. Granting that the patient be not at all injured by the alternation, and even that a prompt and brilliant cure results—then comes the question, Which remedy did the good? As we can never tell this we have made no progress in our learning, have added nothing to our stock of knowledge. I have heard doctors say: "I gave that patient a, b, c and d, in alternation, four hours apart, and he got well rapidly; but bless me if I know which

remedy did the work." What a dearth of science in such a procedure!

5. It encourages careless and consequently incompetent prescribing. A careless driver has more smash-ups than one who is careful or competent. Who would want to cross the ocean with a captain who carelessly glanced at his compass and heedlessly figured out his reckoning instead of taking his bearings with all the skill and power at his command. A slouchy prescriber and a slouchy sea captain are much the same in principle, and each one has a higher death-rate to show than the man who diligently applies himself to his chart on the one hand or to his materia medica on the other. And right here is the secret of most all alternating—ignorance of the materia medica. The physician who alternates does not study his materia medica thoroughly, and carefully sift out the points of difference in remedies having an *apparently* similar line of action. For instance, I have found doctors alternating aconite and bryonia, in perhaps a case of pneumonia. If asked "Why are you doing so?" their reply is, "I am giving aconite for the fever and bryonia for the pain." How utterly absurd—to call it by no harsher name—this is. Aconite for the fever and bryonia for the pain! Of what earthly symptomatic value are *fever* and *pain* in comparison with the mental symptoms or with the aggravations and ameliorations or with many other symptoms we could mention? I know that aconite and bryonia have many symptoms in common, and I am fully aware of the fact that in an acute case it may require some little time and care to decide between the two. But it is better for the patient that we take this time, and it is more scientific for the physician to skilfully untangle these threads of similarity until the preponderance of one or the other remedy shall decide in favor of its administration to the suffering sick one. Now let us try to learn some of the points of difference between aconite and bryonia.

Mental.—You find an aconite patient fearful, anxious, and so restless as to be in constant motion because the motion relieves him—eases his pain and mental agitation somewhat; indeed, motion is so necessary to an aconite patient that to hold him perfectly still so greatly intensifies his sufferings that he struggles to be free to resume his motion.

How different this is from the quiet and motionless bryonia patient; every motion aggravates his sufferings so much that he would thank you for holding him still. Instead of being restless and anxious, like aconite, he is silent and depressed.

Face.—Under aconite we see an anxious expression on the face, and the face is pale; bryonia presents a red or bluish-red face; mouth, tongue, and lips dry and cracked as if burned, with constant chewing motion of the mouth.

Thirst.—Aconite has constant and unquenchable thirst—continually wants water which seems to relieve the mental anxiety. Bryonia has thirst for huge drinks of cold water—will eagerly put out the hand for a large tumblerful and drink it all down, feeling better for a time, even relieving the desire to vomit.

Gastric.—Aconite vomits everything, and in great quanity. Bryonia vomits solid food, but not drink; this vomiting of bryonia is very characteristic—the food does not come all at once, but comes up in mouthfuls, a mouthful at a time.

Pain.—Bryonia is indicated when one is unable to take a deep breath as it produces such a sudden stitch in the chest or side. Aconite is called for when a pain in the back prevents a deep inspiration. Bryonia has excessive tenderness on pressure over the stomach and abdomen, much more tenderness than has aconite.

Stool.—The constipation of bryonia is very marked, the stools being dark, dry, hard and look as if burnt, also very large in size. In aconite, when there is constipation, the stools are clay-colored.

Urine.—Under aconite the urine is, as a rule, *in*frequent and scanty, coming drop by drop, scalding hot, dark red. Under bryonia the urine is *frequent* and scanty, dark colored, or brown like beer.

Menstruation.—The difference in menstruation is highly marked. Under aconite it is too late, too scanty, lasts too long; blood bright, may be *accompanied* by nose-bleed. Bryonia has the flow too early, too profuse; blood dark or brown; nose-bleed *instead* of menstruation.

Cough.--The cough under aconite is worse from lying on either side, but is relieved by lying on the back. Under bryonia the patient must spring up into a sitting posture as soon as the cough comes.

Nervous.—Under aconite, in the nervous system, we find great irritation, trembling, starting, convulsions. Under bryonia there is great prostration and weariness, faintness and exhaustion.

Weather.—Many of the complaints of aconite are caused by exposure to dry, cold air, or a draught of air. Bryonia complaints occur in very hot weather or when the weather becomes warmer.

Aggravations.—Aconite patient usually sleeps better before midnight. Bryonia patient usually sleeps better after midnight. Under aconite the patient is usually worse lying on the painful side, and better when lying on the painless side. Under bryonia the patient is better lying on the painful side than when lying on the painless side.

Aconite is worse and bryonia better under the following conditions: When standing erect; after lying down; in bed; from the warmth of the bed. Aconite is better and bryonia worse after rising from bed; from washing or wetting the affected part; when walking in the open air.

Sides and Hair.—In conclusion, aconite complaints are more frequently found on the left side, and in dark-haired persons. Bryonia attacks by preference the right side and light-haired people.

CLINICAL CONFIRMATIONS.

M. S. WILLIAMSON, M.D., PHILADELPHIA.

It is not my purpose to present a list of symptoms relieved, or to relate a number of brilliant cures, but rather to take a little of your time to study the influence clinical confirmations might have in assisting us to acquire a more accurate knowledge of the materia medica.

Some persons think, to make use of other methods than provings is both misleading and unscientific, and that it is taking a step backward in the direction of empiricism; but they are in error, and the reply to this charge is, that it is only by making use of our experience that we can hope to eliminate worthless in-

dications and place in their proper position the symptoms which are reliable.

Careless examination and hasty conclusions would produce but poor results in anything as difficult as the work before us. We are all familiar with examples of a little learning being a dangerous thing when applied to the practice of medicine, and the use of the little book and box, in the hands of well-meaning people, has frequently been detrimental to Homœopathy and injurious to the sick.

There are many opinions which have a little truth as a foundation, such as the one that aconite is good for every form of fever; these caused the loss of much valuable time in treating desperate cases and have put the life of the patient in jeopardy.

Progress in the study of medicine is not made by a superficial knowledge of thousands of remedies; but by constantly increasing our information about a much smaller number, our methods of inquiry will improve, and we will learn to be much more accurate.

Involuntarily we feel much better satisfied when prescribing a remedy we have frequently made use of to relieve certain symptoms, and the oftener we can relieve these certain symptoms the better pleased we are with our vocation, and better work is the outcome of this confidence, and naturally we will stand higher in public estimation.

How often we flounder in a sea of doubt and despair, and after working hard to find out what remedy will do a patient the greatest good!

After being in practice for a number of years (outside of a small list of old friends which, by our experience, we know will act promptly when indicated), do we feel satisfied that the medicine chosen will do the patient the greatest good and tend most towards the recovery of health?

In studying a particular remedy having hundreds of symptoms, how hard, and often impossible, it is to select the ones of any importance.

Anything that will aid us in the work must not be overlooked, and this promising field has not had the attention that it apparently deserves.

Any of us should be willing to do their full share in communicating their experience in confirming the symptoms of remedies that have been proven by a small number of persons.

It is of great importance to remove the personal factor as much as possible, and, as in the provings, the presence of a vivid imagination, age, sex, occupation, season of the year, diet, exercise, place of living, clothing, and many other things must be taken into consideration to account for the presence or absence of certain symptoms; so, in cases of sickness, all of these must be thought of and possibly the tendency some of us have of giving favorite medicines, does some good, but a little more care would have caused the selection of one that would have done a great deal more for the patient.

A BRIEF STUDY OF ACONITUM NAPELLUS.

C. S. MIDDLETON, M.D., PHILADELPHIA.

With the many additions to our materia medica within the past few years it has become too often the case that some of the older and well-tried medicaments have been supplanted by the new aspirants for favors, much to the disadvantage of the sick.

This fact is the more apparent to the older practitioners of our school than to those of more recent graduation.

Aconite is one of these abused and neglected remedies, gelsemium and ferrum phosphoricum having been used and recommended by many to its exclusion. No more valuable remedy exists in our materia medica than aconite, and no other can supplant it.

Many years ago, upon my initiation into the sacred precincts of medicine, it was the fashion to ridicule the late Dr. Hempel, on account of his just appreciation of the virtues of aconite. "It was a hobby of his," it was said. This was calculated to create a prejudice in the minds of those just beginning the study of medicine. It would have been better for many had they adhered to the old polychrest, instead of severing their allegiance for an equivocal substitute.

From a physiological or pathological standpoint, aconite is an incomparable remedy—no other drug possessing the ability to produce a similar train of symptoms and conditions.

It is the active, irate master of the materia medica, suitable chiefly in the most acute conditions, as its rapid, excited action would imply. Its action is like that of a venomous reptile—harmless if undisturbed—but violently offensive if placed within its power.

This action seems to be one of direct poison to the nerves most easily in contact. In other words, the effects begin directly, and afterwards, by centripetency, the central and other noble organs become affected.

The local action must be first directly irritating, then paralyzing, and, secondly, the same effect is produced upon the grand organ of the circulation, first irritating the heart through the cardiac plexus, increasing its action and flow of blood, and next, in rapid succession, manifesting an inhibitory effect upon the arterioles, wherever the drug has most affinity. We have, then, the essential conditions for producing congestion and inflammation. There seems to be no organ or tissue, notably serous and mucous, where, if the victim of a fatal dose of aconite could live long enough, this effect could not be found.

All drugs possess tissue affinities, but aconite seems first to seek inflammatory action, and next for affinity. In other words, wherever, by favorable conditions, inflammation can be located, the aconite will find its way, either, firstly, by being instrumental in producing congestion and inflammation, or when used curatively in relieving the same. The foregoing remarks are, of course, thoughts emanating from a view of the action of aconite in appreciable and often fatal doses.

It is not the aim of this paper to elaborate comparative symptomatology, as space and time do not permit, but to remind us of the indispensable services of aconite in catarrhal and inflammatory states. When we encounter this condition, *if you are soon enough in the case*, see if aconite is indicated; its timely and judicious use will often save your patient.

In acute cephalic and spinal meningitis, pleuritis, pneumonia, bronchitis, endo- and myo-carditis, pericarditis, gastritis, enter-

itis, dysentery, peritonitis, and that much mistreated inflammatory rheumatism, neuralgia, etc., aconite will often not only relieve pain and inflammation and thus save the patient, but give the doctor much comfort and satisfaction.

In acute meningitis, with cephalic engorgement, with strong, full pulse, bloated, red or purple face, burning and heat in the brain, injected conjunctiva, contracted pupils, delirium, great restlessness, great thirst, dry, hot skin, or the sweat of collapse from heart-failure, aconite should prove curative.

The sharp stitching pain, more or less localized, with hot, dry, skin, in pleurisy calls for the drug.

In intense fever following chill, hot, dry skin, delirium, restlessness, anxiety and fear of death, stitching or sore pain in chest, oppression of breathing, dry cough or bright, bloody, frothy sputum, in pleuro-pneumonia and bronchitis, aconite should lift the patient out of danger.

In the congestive condition of the lungs, accompanying epidemic influenza (la grippe), which recently spread over the country, aconite was invaluable to me.

In peritonitis, I am of the opinion that it has saved more than one patient for me. In a most severe and unpromising case of diffused peritonitis, where the pain and soreness was intense, the temperature over 105° F., the thermometer registered more than three degrees lower in three hours, a profuse sweat accompanying the change, under the use of aconite θ, two-drop doses at intervals of one-half hour. When using this drug in appreciable doses in rapid succession in pneumonia and peritonitis, the patient must be carefully watched, as the tendency to heart-failure in these diseases *might* be enhanced, but I have never experienced any bad effects; on the contrary, most salutary results have followed. Much better than I could imagine from the use of antipyrine or antifebrine, which I have never used.

The grand characteristic for the use of aconite is, first *inflammation*, then must we have the special symptoms, the acute, severe pain and soreness, high temperature, hot, dry skin, great thirst, etc. In hæmoptysis (from local congestion), bright red blood, clear and frothy, in dysentery the same bright blood, or bloody mucus, will often yield to aconite.

Many cases of neuralgia, especially of the fifth pair of nerves, and of the cardiac plexus have been cured by aconite.

Some time since a case came under my charge of neuralgia of the fifth pair, of many years' standing, in which an operation, for either stretching or excising a portion of the nerve was insisted upon by a noted surgeon of this city. The patient, although advanced in years, remained almost entirely free from pain after the use of aconite θ in drop doses.

From the well known action of aconite it follows that it must prove often efficacious in cardiac paralysis, especially when over-action of the heart has preceded the failure. It must not be inferred that it is always necessary to use aconite in appreciable doses, as the writer derives satisfactory results from the 6th and 30th potencies even. But it must be remembered that for some of the most acute cases immediate action is called for; the cases are excessively acute, and unless you get the good effects from your remedy promptly, the case will not only have passed beyond the help of aconite, but also into a condition much more advanced, or perhaps helpless. Aconite is a quickly acting drug, and its effects are either rapid in their fatality or recovery, from even quite large doses, and will begin in a few hours.

THE SPIDER-POISONS.

EDWARD CRANCH, M.D., ERIE.

ALL that can be said now on these interesting medicaments, can be said only as a brief supplement to Farrington's lecture on the arachnidæ, in his *Clinical Materia Medica.* These poisons are clearly of no imaginable use to any but a Homœopath, not only because they are hard to obtain in crude form in any quantity, but also because their primary action is so severe, general, and destructive, that no such effects are for a moment to be sought for either as palliatives, counter-irritants, or alteratives.

There remains only the Homœopathic action, or the *opposite action* of small doses, which Lauder Brunton says is not Homœo-

pathic at all! A general view of these spider-poisons shows that they all cause severe and profound action on mental, motor, and tissue-sustaining forces.

A characteristic action is that of painful restlessness, of slow-healing ulcers, boils, carbuncles, and eczematous eruptions, and of p ofound mental and nervous prostration. In these three fields they do unequalled work. Their restlessness is excessive; the pain, a general and particular sense of anguish, and the mental states introduce to imbecility and mania.

They may be differentiated from all other remedies by the combination of pain and restlessness unrelieved by motion, and the sluggishness of healing processes, announcing the most profound disturbances of nutrition. In this latter feature, they approach the snake-poisons, but in the general painful fidgetiness they stand alone.

Among themselves, they have not yet been all sufficiently proven. In a general way it may be said that *mygale* stands for chorea, and also for chordee and chancre; lycosa tarantula for frantic, sly, hysteria, and a more superficial eruptiveness; tarantula cubensis for painful carbuncles, commencing varicose ulcers, chronic phthisis; aranea diadema for disease of the os calcis, and in general, for a peculiar aggravation of any ailment from dampness; while theridion stands for scrofula, quick consumption, aggravation from cold and from noise. Trombidium, the poison of an arachnid (though not a true spider), may be mentioned as a promising drug in pterygium, and in diarrhœa with prolapsus, rivalling podophyllum, but more painful. If these few hints serve to put any one on the track of a desired remedy, their only purpose is fulfilled.

DISCUSSION.

Dr. Z. T. Miller spoke of having used tarantula cubensis in a number of cases of carbuncle. One, in particular, he called to mind, where the carbuncle was on the cheek; it was red, burning, smarting, and hard, with a number of small openings through which exuded a considerable quantity of pus. The remedy afforded almost immediate relief.

KALI.

E. D. GOFF, M.D., ALLEGHENY CITY.

HAVING been requested to prepare a paper for the Bureau of Materia Medica, to be read at this meeting, I have selected kali as my subject.

Potassium, the base of the kali compounds, has been supposed to exist from the latter part of the last century, but its existence was only made positive by Sir Humphrey Davy in the year 1807.

Experiments by Guy Lussac and Lavoissier for the discovery of the metal, had only, in part, established the fact of its existence. The discovery was made by passing a strong current of a voltaic battery through a fragment of hydrate of potash. It was decomposed, the potassium separating as globules at the negative pole, while its component gases were evolved at the positive. In 1808, Guy Lussac and Thenard obtained the metal by a chemical process, decomposing the potash by using metallic iron at a white heat. The oxygen of the potash combined with the iron, and the potassium in gaseous form was condensed in a receiver filled with naphtha or purified rock-oil. The method now used, called Brunner's method, consists in the distillation of a mixture of carbonate of potassium and charcoal at a white heat in an iron retort. The chief characteristics of the metal are the blueish-white color, and the strong metallic lustre. At 32 degrees, it is brittle, and has a crystalline fracture; at a higher temperature, it is malleable; at 60 degrees, it is soft with the consistency of wax; at 130 degrees, it becomes a liquid, and at a red heat a beautiful green vapor.

Its intense affinity for oxygen is demonstrated by throwing small pieces in a basin of water. Its low specific gravity allows it to float. The potassium decomposing the water, and combining with the oxygen forms the oxide of that metal. The liberated hydrogen carries off a small portion of the volatilized potassium, and taking fire from the heat evolved by the chemical action burns with a brilliant violet flame. At an elevated temperature this metal extracts oxygen from almost all bodies into the composi-

tion of which that element enters. It is frequently used in laboratories to remove all traces of oxygen from the hydro-carbons. Potassium must be kept in naphtha or purified rock oil on account of its affinity for oxygen.

The salts which potassium forms with the acids are mostly soluble in water, and colorless, excepting the permanganate. Most of them can be crystallized, and communicate a violet tint to the spirits of wine or to the blow pipe.

Potassium is an alkaline metal, having for its symbol K., the first letter of the Arabian word kali. Its richest store is found in the ocean. It also enters into the formation of many rocks, whose disintegration furnishes directly or indirectly the soluble potassium salts, which are found in many fertile soils. These salts being absorbed by the roots of vegetable and woody growths furnish a considerable part of their nutrition and become a constituent of their bulk. In the ashes of most land plants, potash is said to form upwards of 90 per cent. of the total alkali. Formerly potash was made exclusively from wood ashes, and even now this industry is extensively carried on in wood producing sections of America and Europe. Household ashes furnish the raw material. These are lixiviated with water, which dissolves all the carbonates of potash with more or less of the sulphates and silicates, while the earthy phosphates, carbonates and other insolubles remain as a residue. The clarified solution is evaporated to dryness in iron basins. Formerly this process was effected in iron pots, hence, the name potash was given to the product. The crude potash is extensively used in the arts, the manufacture of glass, after being causticized, in making of soaps, and combined with nitric acid it enters into the manufacture of gunpowder. The purified carbonate is known to commerce as pearl ash.

The kalis are irritants, and principally effect the mucous membranes of the respiratory and alimentary tracts, the glandular system, skin, fibrous tissue, and cartilage. Its action represents congestion, disorganization, and even destruction of tissue. Hemple relates an instance of the destructive power of bichromicum, where the destruction of the septem narium occurred in individuals employed in its production.

In moderate doses, kali acts as a purgative, and in large doses as a poison. It is said to cause eruptions over the entire body, with intense itching, smarting and burning. In the normal condition the skin is not effected by contact; but if there is the slightest abrasion, the caustic character of the salt is shown, and destruction of tissue occurs, at times penetrating to the bone.

Kali bromatum and kali nitricum differ from the other kalis in that their action on the nerves and spinal system are their most prominent characteristics. The physiological action of kali bromatum is not fully determined. Cowperthwaite says it is supposed to act on the peripheral ends of the efferent nerves, causing paralysis, and more or less affecting the cerebrum, causing weakness of mind, hallucinations, epilepsy, and the heart may be paralyzed under its influence; while through spasms of the vasomotor system, it causes contraction of the bloodvessels followed by dilatation. The subsequent dilatation gives rise secondarily to congestion, exciting the depressed nerve-centres to a morbidly increased action of both sensory and motor nerves, and often giving rise to hyperæsthesia and convulsions.

According to Dr. Hale, it is Homœopathic to all the morbid conditions and symptoms in which it has been found useful in the Old School of medicine.

DISCUSSION.

Dr. Van Artsdalen has verified the facts regarding the treatment of skin diseases. The fine, needly pains are usually relieved promptly by kali bichromium. If there is some eruption, bathe the part with a weak solution of kali permanganum.

GENERAL BUSINESS.

During the session Dr. Robert W. McClelland presented the following resolution:

Resolved, That this society, fully recognizing the contagious character of consumption, as propagated by the sputum, hereby heartily indorses the work being done by the Women's Health Protective Association.

It is also of opinion that if the measures as recommended by the association could be generally adopted much good would result in the limitation of the disease.

On motion, this resolution was referred to a committee of three, consisting of Drs. R. W. McClelland, W. J. Martin and J. R. Horner, with instructions to report later.

A number of bills were presented by the parties into whose hands they had come and ordered paid.

W. H. Winslow, M.D., resigned.

Drs. Cooper, Bushrod James and Horner were appointed a Committee on Subscription.

A special committee, consisting of Drs. Parsons, Willard and Hugh Pitcairn, appointed to consider the necessity for action on medical legislation, made the following report:

To the President and Members of the Homœopathic Medical Society of the State of Pennsylvania:

We, your committee, appointed to consider and report as to the course and plan of action best to be pursued by this society, would suggest that inasmuch as no legislation relative to an educational or licensing board can take place prior to the next annual session of this society, we would therefore recommend that a committee of five members be appointed to conserve and protect the interests of Homœopathy so far as possible in the State, and to draft a plan

and method promising the best legislative enactment at the earliest possible period, and report the same at the next annual meeting of this society.

E. C. PARSONS,
L. H. WILLARD.

Dr. Hugh Pitcairn was appointed chairman of the special Committee on Legislation, with the privilege of choosing his own conferees.

The Committee on President's Address made their report as follows:

REPORT OF THE COMMITTEE ON THE PRESIDENT'S ADDRESS.

TO THE HOMŒOPATHIC MEDICAL SOCIETY OF THE STATE OF PENNSYLVANIA:

Your committee to which was referred the president's address would respectfully report, that after a careful consideration of the address they fully indorse what is therein contained, and would particularly emphasize the necessity of our school being on the alert to prevent the machinations of "our friends, the enemy," in their endeavors to deprive us of our equal privilege in the establishing of examining boards, and in asserting our right to have the proposed asylum for the insane under Homœopathic control. We do not ask this as a favor, *but demand it as a right.* Our clientele is large enough, and wealthy enough, and influential enough, to make our demand efficient *in procuring this means of comparison between the old and new school methods of treating the insane,* if we, who are so vitally interested, will but wake up from our lethargy and "fight the devil with fire." Our appeal must be to the people, who will see, if we properly urge the matter, that we get our rights. In any event we must persistently press our claims to public recognition until we have secured the same privileges enjoyed by the dominant school in the public charitable institutions of the State.

The excellence of the address impels us to propose that the Publication Committee be instructed to have printed separately a sufficient number of copies of the address for distribution to the members of the society, members of the Legislature and all others in whose hands it might work for the good of our cause.

We would also suggest that, in conformity to the recommendation of the president, a special committee be appointed authorized to employ all lawful means to secure that which our patients have a just right to demand, *i.e.*, just representation in State charities.

C. C. Rhinehart, M.D.,
A. P. Bowie, M.D.,
W. J. Martin, M.D.,
Jos. E. Jones, M.D.,
C. A. Yocum, M.D.

Prof. John C. Sanders, M.D., of Cleveland, and R. B. Rush, M.D., of Salem, O., by unanimous rising vote of the Society were elected to honorary membership.

There being no further business before the Society, the election of officers for the ensuing year was held, and resulted as follows:

President.—E. C. Parsons, M.D., Meadville.

First Vice-President.—F. R. Schmucker, M.D., Reading.

Second Vice-President.—Sarah J. Coe, M.D., Wilkesbarre.

Treasurer.—J. F. Cooper, M.D., Allegheny.

Corresponding Secretary.—E. R. Snader, M.D., Philadelphia.

Recording Secretary.—J. R. Horner, M.D., Allegheny.

Necrologist.—W. J. Martin, M.D., Pittsburgh.

Censors.—M. J. Chapman, M.D., Pittsburgh; Clarence Bartlett, M.D., Philadelphia; Jos. E. Jones, M.D., West Chester.

The following bureaus and committees were then announced:

Bureau of Clinical Medicine.—W. W. Van Baun, M.D., Chairman; Drs. Aug. Korndœrfer, C. G. Raue, C. F. Bingaman, C. Bartlett, W. C. Goodno, J. A. Bullard, Silas Griffith, O. S. Haines, E. R. Snader, J. G. Fickel, C. B. Knerr, Daniel Karsner, Francis W. Boyer, Hugh Pitcairn, Mary Branson, Geo. W. Titman, Wm. A. Haman, J. Richey Horner, Samuel Starr, L. W. Reading, W. J. Martin, W. A. Seibert.

Surgery.—Landreth W. Thomson, M.D., Chairman; Drs. John E. James, Charles M. Thomas, C. P. Seip, W. B. Van Lennep, J. H. McClelland, L. H. Willard, C. V. Vischer, J. H. Thomson, J. W. Giles, H. L. Northrop, C. A. Wilson, W. A. Haman, Thos. Reading.

Obstetrics.—H. M. Bunting M.D., Chairman; Drs. Horace

Still, Isaac Crowther, J. B. McClelland, W. G. Dietz, J. N. Mitchell, Hugh Pitcairn, W. H. Tomlinson, M. W. Williamson, W. C. Paull.

Gynæcology.—S. J. Coe, M.D., Chairman; Drs. J. W. Coolidge, L. M. Johnson, Harriet J. Sartain, L. W. Reading, C. H. Hofmann, Emma T. Schreiner, Pearl Starr, P. A. Bier, Eliza J. L. McClure, F. W. Boyer.

Pathology and Pathological Anatomy.—Carl V. Vischer, M.D., Chairman; Drs. W. K. Ingersoll, Theo. J. Gramm, Landreth W. Thompson, James F. Cullin.

Opthalmology, Otology and Laryngology.—H. K. Hoy, M.D., Chairman; Drs. C. M. Thomas, Augustus Korndœrfer, W. H. Bigler, J. H. McClelland, W. W. Speakman, H. F. Ivins, I. G. Shallcross, F. W. Messervé.

Pædology.—John S. Ferson, M.D., Chairman; Drs. Millie J. Chapman, Z. T. Miller, W. J. Martin, W. G. Dietz, H. S. Phillips, R. S. Marshall, E. S. Sharpless, H. W. Fulton.

Sanitary Science.—J. F. Cooper, M.D., Chairman; Drs. J. C. Burgher, John C. Morgan, B. W. James, P. Dudley, A. Korndœrfer, M. M. Walker, J. C. Guernsey.

Committee on State Legislation.—Hugh Pitcairn, M.D., Chairman; Ross Swarts, M.D., Secretary; Drs. W. B. Van Lennep, E. C. Parsons, L. H. Willard.

Delegate to the American Institute of Homœopathy. —Joseph E. Jones, M.D.

Delegate to the Southern Institute of Homœopathy. Millie J. Chapman, M.D.

Committee on Publication.—Drs. Edward R. Snader, J. Richey Horner, J. F. Cooper.

Special Committee on Resolutions.—Drs. R. W. McClelland, W. J. Martin, J. Richey Horner.

Committee on Subscriptions.—Drs. J. F. Cooper, J. Richey Horner, Bushrod W. James.

Philadelphia was selected as the place of meeting in 1892.

On motion, a unanimous vote of thanks was tendered to President Korndœrfer for his able and efficient conduct of the business of the Sooiety; to the authorities of the Hospital for the use of

the assembly room; and to the Allegheny County Homœopathic Medical Society.

A vote of thanks was also tendered the press of Pittsburgh for the uniformly good reports of the meetings.

On motion, the Society adjourned.

Respectfully submitted,

J. R. Horner.
Recording Secretary.

MEMBERS PRESENT.

P. A. Bier,
C. F. Bingaman.
A. P. Bowie,
G. S. Boyd,
J. S. Boyd,
E. E. Briggs,
H. M. Bunting,
J. C. Burgher,
M. J. Chapman,
J. Cooper,
J. F. Cooper,
J. S. Crawford,
E. W. Dean,
W. G. Dietz,
S. W. S. Dinsmore,
P. S. Duff,
W. F. Edmundson,
H. J. Evans,
L. L. Ferson,
R. K. Fleming,
H. W. Fulton,
Chas. Gangloff,
G. M. Getze,
T. H. Grimes,
C. H. Hofmann,
J. R. Holcombe,
J. R. Horner,
M. R. Jamison,
Jos. E. Jones,
W. D. King,
Ang. Korndœrfer,
Alfred Layman,
W. J. Martin,
J. B. McClelland,
R. W. McClelland,
Z. T. Miller,
E. C. Parsons,
Wm. Peach,
J. B. Phillips,
H. S. Phillips,
Hugh Pitcairn,
R. V. Pitcairn,
J. S. Rankin,
C. C. Rinehart,
L. G. Rousseau,
C. L. Rumsey,
F. R. Schmucker,
C. P. Seip.
O. R. Shannon,
J. S. Skeels,
Mary E. Smith,
E. R. Snader,
Pearl Starr,
H. B. Tindall,
J. H. Thompson,
L. W. Thompson,
L. H. Willard,
C. A. Wilson,
R. T. White,
C. A. Yocum,
C. Van Artsdalen.

OFFICERS OF THE SOCIETY FROM ITS ORGANIZATION TO THE PRESENT TIME.

Session of 1866.

J. B. WOOD, M.D., President.
J. H. P. FROST, M.D., First Vice-President.
J. C. BURGHER, M.D., Second Vice-President.
B. W. JAMES, M.D., Recording Secretary.
R. J. McCLATCHEY, M.D., Corresponding Secretary.
D. COWLEY, M.D., Treasurer.

Session of 1867.

W. WILLIAMSON, M.D., President.
J. H. MARSDEN, M.D., First Vice-President.
W. J. BLAKELY, M.D., Second Vice-President.
B. W. JAMES, M.D., Recording Secretary.
R. J. McCLATCHEY, M.D., Corresponding Secretary.
H. H. HOFMANN, M.D., Treasurer.

Session of 1868.

C. PRESTON, M.D., President.
H. H. HOFMANN, M.D., First Vice-President.
J. J. DETWILLER, M.D., Second Vice-President.
B. W. JAMES, M D., Recording Secretary.
R. J. McCLATCHEY, M.D., Corresponding Secretary.
W. M. WILLIAMSON, M.D., Treasurer.

Session of 1869.

This session was presided over by Walter Williamson, M.D., in the absence of the President and Vice-President, and by special resolution adopted at the commencement of that session, the officers for 1870 were elected immediately prior to the adjournment of the meeting.

Session of 1870.

[*Held in Erie, June* 3 *and* 4, 1870.]

O B. GAUSE, M.D., President.
C. A. STEVENS, M.D., First Vice-President.
J. H. McCLELLAND, M.D., Second Vice-President.
B. W. JAMES, M.D., Recording Secretary.
R. J. McCLATCHEY, M.D., Corresponding Secretary.
W. J. BLAKELY, M.D., Treasurer.

Session of 1871.

[*Held in Harrisburg, February* 1 *and* 2, 1871.]

M. COTE, M.D., President.
R. FAULKNER, M.D., First Vice-President.
H. M. LOGEE, Second Vice-President.
B. W. JAMES, M.D., Recording Secretary.
R. J. McCLATCHEY, M.D., Corresponding Secretary.
O. B. GAUSE, Treasurer.

Session of 1872.

[*Held in Harrisburg, February* 6 *and* 7, 1872.]

J. H. MARSDEN, M.D., President.
H. N. GUERNSEY, M.D., First Vice-President.
S. F. CHARLTON, M.D, Second Vice-President.
B. W. JAMES, M.D., Recording Secretary.
R. J. McCLATCHEY, M.D., Corresponding Secretary.
O. B. GAUSE, M.D., Treasurer.
W. R. CHILDS, M.D., Necrologist.

Session of 1873.

[*Held in Harrisburg, February* 6 *and* 7, 1873.]

B. W. JAMES, M.D., President.
M. PRESTON, M.D., First Vice-President.
J. C. BURGHER, M.D., Second Vice-President.
M. M. WALKER, M.D., Recording Secretary.
P. DUDLEY, M.D., Corresponding Secretary.
O. B. GAUSE, M.D., Treasurer.
W. R. CHILDS, M.D., Necrologist.

Session of 1873.

[*Held in Harrisburg, October* 1 *and* 2, 1873.]

J. F. COOPER, M.D., President.
M. FRIESE, M.D., First Vice President.
H. R. FETTERHOFF, M.D., Second Vice-President.
M. M. WALKER, M.D., Recording Secretary.
P. DUDLEY, M.D., Corresponding Secretary.
R. J. McCLATCHEY, M.D., Treasurer.
W. R. CHILDS, M.D., Necrologist.

Session of 1874.

[*Held in Philadelphia, October* 7 *and* 8, 1874.]

C. A. STEVENS, M.D., President.
I. LEFEVER, M.D., First Vice-President.
W. F. SPETH, M.D., Second Vice-President.

M. M. WALKER, M.D., Recording Secretary.
P. DUDLEY, M.D., Corresponding Secretary.
R. J. McCLATCHEY, M.D., Treasurer.
W. R. CHILDS, M.D., Necrologist.

Session of 1875.

[*Held in Pittsburgh, October* 13 *and* 14, 1875.]

R. J. McCLATCHEY, M.D., President.
J. E. JONES, M.D., First Vice-President.
H. N. MARTIN, M.D., Second Vice-President.
M. M. WALKER, M.D., Recording Secretary.
P. DUDLEY, M.D., Corrresponding Secretary.
J. F. COOPER, M.D., Treasurer.
W. R. CHILDS, M.D., Necrologist.

Session of 1876.

J. E. JONES, M.D., President.
J. C. BURGHER, M.D., First Vice-President.
J. E. JAMES, M.D., Second Vice-President.
M. M. WALKER, M.D., Recording Secretary.
J. C. GUERNSEY, M.D., Corresponding Secretary.
J. F. COOPER, M.D., Treasurer.
W. R. CHILDS, M.D., Necrologist.

Session of 1877.

J. C. BURGHER, M.D., President.
L. H. WILLARD, M.D., First Vice-President.
J. E. JAMES, M.D., Second Vice-President.
M. M. WALKER, M.D., Recording Secretary.
J. C. GUERNSEY, M.D., Corresponding Secretary.
J. F. COOPER, M.D., Treasurer.
W. R. CHILDS, M.D., Necrologist.

Session of 1878.

[*Held in Pittsburgh, September* 25 *and* 28, 1878.]

H. N. GUERNSEY, M.D., President.
W. R. CHILDS, M.D., First Vice-President.
A. KORNDŒRFER, M.D., Second Vice-President.
M. M. WALKER, M.D., Recording Secretary.
J. C. GUERNSEY, M.D., Corresponding Secretary.
J. F. COOPER, M.D., Treasurer.
W. R. CHILDS, M.D., Necrologist.

Session of 1879.

[*Held in Cresson, September* 2 *and* 3, 1879.]

L. H. WILLARD, M.D., President.
M. M. WALKER, M.D., First Vice-President.
L. M. ROSSEAU, M.D., Second Vice-President.
Z. T. MILLER, M.D., Recording Secretary.
J. C. GUERNSEY, M.D., Corresponding Secretary.
J. F. COOPER, M.D., Treasurer.
W. R. CHILDS, M.D., Necrologist.

Session of 1880.

[*Held in Easton, September* 8 *and* 9, 1880.]

J. K. LEE, M.D., President.
H. DETWILLER, M.D., First Vice-President.
J. WESLEY ALLEN, M.D., Second Vice-President.
Z. T. MILLER, M.D., Recording Secretary.
R. E. CARUTHERS, M.D., Corresponding Secretary.
J. F. COOPER, M.D., Treasurer.
W. R. CHILDS, M.D., Necrologist.

Session of 1881.

J. H. McCLELLAND, M.D., President.
B. F. BETTS, M.D., First Vice-President.
J. J. DETWILLER, M.D., Second Vice-President.
Z. T. MILLER, M.D., Recording Secretary.
R. E. CARUTHERS, M.D., Corresponding Secretary.
J. F. COOPER, M.D., Treasurer.
W. R. CHILDS, M.D., Necrologist.

Session of 1882.

W. R. CHILDS, M.D., Necrologist.

Session of 1883.

[*Held in Philadelphia, September* 18 *to* 20, 1883.]

P. DUDLEY, M.D., President.
HUGH PITCAIRN, M.D., First Vice-President.
C. F. BINGAMAN, M.D., Second Vice-President.
T. M. STRONG, M.D., Recording Secretary.
R. E. CARUTHERS, M.D., Corresponding Secretary.
J. F. COOPER, M.D., Treasurer.
W. R. CHILDS, M.D., Necrologist.

Session of 1884.

[*Held in Pittsburgh, September* 16 *to* 18, 1884.]

W. R. CHILDS, M.D., President.
C. MOHR, M.D., First Vice-President.
H. DETWILLER, M.D., Second Vice-President.
C. BARTLETT, M.D., Recording Secretary.
R. E. CARUTHERS, M.D., Corresponding Secretary.
J. F. COOPER, M.D., Treasurer.
M. M. WALKER, M.D., Necrologist.

Session of 1885.

[*Held in Philadelphia, September* 23 *to* 25, 1885.]

JNO. E. JAMES, M.D., President.
D. COWLEY, M.D., First Vice-President.
J. K. LEE, M.D., Second Vice-President.
C. BARTLETT, M.D., Recording Secretary.
R. E. CARUTHERS, M.D., Corresponding Secretary.
J. F. COOPER, M.D, Treasurer.
W. R. CHILDS, M.D., Necrologist.

Session of 1886.

[*Held in Philadelphia, September* 20 *to* 23, 1886.]

D. COWLEY, M.D., President.
W. H. BIGLER, M.D., First Vice-President.
J. R. READING, M.D., Second Vice-President.
HORACE F. IVINS, M.D., Recording Secretary.
CLARENCE BARTLETT, M.D., Corresponding Secretary.
J. F. COOPER, M.D., Treasurer,
W. R. CHILDS, M.D., Necrologist.

Session of 1887.

[*Held in Pittsburgh, September* 20 *to* 22, 1887.]

A. R. THOMAS, M.D., President.
W. J. MARTIN, M.D., First Vice-President.
EDW. CRANCH, M.D., Second Vice-President.
HORACE F. IVINS, M.D., Recording Secretary.
CLARENCE BARTLETT, M.D., Corresponding Secretary.
J. F. COOPER, M.D., Treasurer.
W. R. CHILDS, M.D., Necrologist.

Session of 1888.

[*Held in Philadelphia, September* 18 *to* 20, 1888.]

HUGH PITCAIRN, M.D., President.
W. B. TRITES, M.D., First Vice-President.
C. F. BINGAMAN, M.D., Second Vice-President.

J. H. CLOSSON, M.D., Recording Secretary.
CLARENCE BARTLETT, M.D., Corresponding Secretary.
J. F. COOPER, M.D., Treasurer.
W. R. CHILDS, M.D., Necrologist.

Session of 1889.

[*Held in Pittsburgh, September* 17 *to* 19, 1889.]

W. B. TRITES, M.D., President.
C. F. BINGAMAN, M.D., First Vice-President.
JOHN MALIN, M.D., Second Vice-President.
J. H. CLOSSON, M.D., Recording Secretary.
E. R. SNADER, M.D., Corresponding Secretary.
J. F. COOPER, M.D., Treasurer.
W. R. CHILDS, M.D., Necrologist.
J. RICHEY HORNER, M.D., Vice-Necrologist.

Session of 1890.

[*Held in Philadelphia, September* 17 *to* 19, 1890.]

C. F. BINGAMAN, M.D., President.
C. S. MIDDLETON, M.D., First Vice President.
C. H. LEE, M.D., Second Vice-President.
J. RICHEY HORNER, M.D., Recording Secretary.
E. R. SNADER, M.D., Corresponding Secretary.
J. F. COOPER, M.D., Treasurer.
W. J. MARTIN, M.D., Necrologist.

Session of 1891.

[*Held in Pittsburgh, September* 15 *to* 17, 1891.]

AUGUSTUS KORNDŒRFER, M.D., President.
E. C. PARSONS, M.D., First Vice-President.
M. J. CHAPMAN, M.D., Second Vice-President.
J. F. COOPER, M.D., Treasurer.
E. R. SNADER, M.D., Corresponding Secretary.
J. RICHEY HORNER, M.D., Recording Secretary.
W. J. MARTIN, M.D., Necrologist.

VISITORS PRESENT.

Dr. E. H. Pond,
Dr. S. M. Rinehart,
Dr. C. A. Beach,
Dr. F. W. Burlingame,
Dr. F. E. Harpel,
Dr. W. H. Lee,
Dr. W. R. Stephens,
Dr. W. H. Hart,
Dr. W. W. Cole,
Dr. J. Ely,
Dr. G. A. Mueller,
Miss Maggie Hamilton.
Miss E. Bingaman,
Mrs. G. S. Boyd,
Mrs. W. D. Slack,
Judge J. S. Slagle,
Mrs. S. A. McClung,
Mrs. Thos. Ewing,
Mrs. H. W. Fulton,
Judge J. W. Over,
Major Geo. L. McCoy,
Dr. R. B. Rush,
Dr. J. C. Sanders,
Dr. Ella D. Goff,
Dr. J. C. M. Drake,
D. L. L. Lazear,
Dr. Chas. Gangloff, Jun.,
Dr. B. L. Davis,
Dr. J. S. Cleeland,
Dr. G. L. Moreland,
Dr. R. S. Marshall,
Dr. J. C. McCauley,
Mrs. H. J. Evans,
Mrs. J. E. Jones,
Miss Agnes Duff,
Miss W. D. Slack,
Miss M. Morrison,
Judge S. A. McClung,
Judge Thos. Ewing,
Miss Mary McClelland,
Mrs. E. E. Briggs,
Mrs. J. W. Over,
Mrs. G. L. McCoy.

CONSTITUTION AND BY-LAWS.

CONSTITUTION.

ARTICLE I.—Name and Object.

This Association shall be known as the Homœopathic Medical Society of the State of Pennsylvania.

Its object is the advancement of medical science.

ARTICLE II.—Members.

This Society shall be composed of active, honorary and corresponding members, who shall be chosen in conformity with the By-Laws.

ARTICLE III.—Officers.

The officers of this Society shall be a President, two Vice-Presidents, a Recording Secretary, a Corresponding Secretary, a Treasurer, a Necrologist and a Board of Censors, consisting of three members, who shall be chosen at such time, in such manner and for such a period, and shall perform such duties as the By-Laws may direct.

ARTICLE IV.—Amendment.

The Constitution may be altered or amended by a vote of two-thirds of the members present at the annual meeting; *provided*, that notice of such intended alteration or amendment shall have been given to the Society, in writing, at the annual meeting next preceding.

BY-LAWS.

ARTICLE I.—Meetings.

Section 1. The annual meeting of this Society shall be held at ten A.M., at the time and place decided upon at the annual session next preceding.

Seven members shall constitute a quorum for the transaction of business.

Sec. 2. The elected officers of the Society shall have power to direct such other meetings to be held as they may judge advisable.

Sec. 3. Should any occasion arise making it advisable or necessary to change the time and place of meeting agreed upon at the previous annual meeting, the same may be done by a vote of two-thirds of the officers of the Society, with the concurrence of the Committee of Arrangements.

ARTICLE II.—Officers.

The officers shall be elected by ballot at each annual meeting of the Society, and shall enter upon their respective duties on the first day of January next succeeding their election.

ARTICLE III.—Duties of Officers.

Section 1. The President shall preside at the meetings of the Society, preserve order therein, put questions, announce decisions, and appoint committees not otherwise ordered. He shall deliver an address at the opening of the session.

Sec. 2. The Vice-Presidents, in the order of their election, shall perform the duties of the President in his absence.

Sec. 3. The Recording Secretary shall keep a record of all the proceedings and resolutions, and of all discussions that may occur in the Society; authenticate, by his signature, all papers and acts of the Society, when the occasion requires it, and bring before the Society any business needing its action not otherwise presented.

Sec. 4. The Corresponding Secretary shall receive and preserve all letters addressed directly to the Society; open and maintain such correspondence as shall tend to advance its interests; give

at least two weeks' notice to the members of all meetings of the Society; keep a record of all members, with the date of admission of each; present all communications to the Society; notify all committees of their appointment and of the business referred to them, and notify all members of their election. He shall be *ex officio* Chairman of the Bureau of Organization, Registration and Statistics.

SEC. 5. The Treasurer shall notify, annually, all members of arrearages, collect all money belonging to the Society, and make all disbursements ordered by the Society. He shall furnish, at each annual meeting, a written report of his receipts and expenditures, and a statement of the condition of the finances.

SEC. 6. The Necrologist shall, upon the death of a member of the Society, prepare a suitable obituary and present it to the Society; he shall also forward a copy, properly engrossed, to the family of the deceased member, if so ordered by the Society.

The report of the Necrologist shall be presented in connection with the report and papers of the Bureau of Organization, Registration and Statistics.

SEC. 7. The Censors shall receive and examine the credentials of candidates for membership, and shall report to the Society, for election, such as may be found to be properly qualified.

Their report can be made in its regular order, or at the close of the report of any bureau.

ARTICLE IV.—MEMBERSHIP.

SECTION 1. *Active.*—A candidate for active membership may present to the Board of Censors a written application, signed by himself, accompanied by a certificate from two members of the Society in good standing, that the applicant has received the degree of Doctor of Medicine from an incorporated medical college, that he subscribes to the doctrines of *Similia Similibus Curantur*, and that he sustains a good moral character. If found qualified, he may be elected a member. He shall not, however, be considered a member until he has paid an initiation fee of five dollars (which includes the first year's dues), and signed the Constitution, either in person or by proxy.

Any active member removing from the State wishing to retain

his membership shall notify the Society to that effect; otherwise his name shall be dropped from the roll.

Any active member who fails either to attend the annual meeting or to send a paper once in five years, or to pay his dues, shall, upon vote of the Society, be dropped from membership.

Any member who shall be unable to comply with the requirements of this Society may be continued as an active member, without payment of dues, by vote of the Society.

SEC. 2 *Honorary.*—Any Homœopathic physician, not a resident of Pennsylvania, who, from his superior attainments, may be judged worthy, may be elected an honorary member at any annual meeting, but no more than two shall be elected in one year.

Such honorary members shall have all the privileges of members, except the right to vote and to hold office.

SEC. 3. *Corresponding.*—Any Homœopathic physician residing outside of the United States may be elected a corresponding member at any annual meeting, but not more than two shall be elected in one year.

Such corresponding members shall have all the privileges of members, except the right to vote and hold office.

ARTICLE V.—DUES.

Active members shall pay annually, in advance, the sum of three dollars towards defraying the expenses of the Society.

The published proceedings of the Society will be furnished only to those members who are not in arrears.

ARTICLE VI.—BUREAUS AND COMMITTEES.

SECTION 1. The following Bureaus shall be appointed as hereinafter provided:

One of Materia Medica and Provings.

One of Homœopathic Institutes and Clinical Medicine.

One of Surgery.

One of Obstetrics.

One of Gynæcology.

One of Pathology and Pathological Anatomy.

One of Ophthalmology, Otology and Laryngology.

One of Pædology.

One of Sanitary Science.

One of Organization, Registration and Statistics.

SEC. 2. Each bureau shall be composed of not less than five members.

SEC. 3. Each bureau shall present, in its annaal report, a *résumé* of the discoveries and progress in its special department, together with the papers presented for discussion. The bureaus shall report in order of rotation each succeeding year.

SEC. 4. The Bureau of Organization, Registration and Statistics shall receive all credentials of delegates to the Society; receive and preserve all reports from local or State societies, colleges and other institutions; keep a record of the number of members admitted and withdrawn from the Society; solicit an exchange of publications with other State societies, and perform such other duties as may be directed by the Society. From these data the annual report of the bureau shall be prepared.

SEC. 5. Immediately upon the close of the report of a bureau, the President shall appoint a chairman for the ensuing year; and the chairman so appointed shall, in conjunction with the President, select his associates, and the list of members of the bureau shall be announced before the close of the session.

SEC. 6. If any member of a bureau shall resign or decline to serve, the chairman of the bureau shall fill the vacancy by appointment, and notify the Corresponding Secretary of the fact.

SEC. 7. The following Standing Committees shall be appointed, as hereinafter provided for:

A Legislative Committee.

A Publishing Committee.

SEC. 8. Each of these committees shall consist of at least three members, to be appointed by the President.

SEC. 9. The Legislative Committee shall give special attention to all legislation involving the interests of the Society.

SEC. 10. The Publishing Committee shall publish and issue the Transactions to all who are entitled to receive them within three months from the date of the meeting, unless otherwise directed by the Society at its annual meeting.

The Recording and Corresponding Secretaries and the Treasurer shall constitute this committee, but the number of members may be increased at the discretion of the Society.

ARTICLE VII.—Papers and Discussions.

Section 1. Each paper presented to the Society shall be through its appropriate bureau. All papers to be presented by any bureau shall be in the hands of the chairman thereof at the opening of the session; and it shall be the duty of each writer to prepare an abstract, which will accompany the paper when handed in, and the chairman shall decide whether the abstract only or the entire paper be presented to the meeting for its consideration and discussion. All papers shall be subject to the approval and revision of the Committee of Publication. No report or paper will be received by the Society in an incomplete or unfinished condition, and no paper shall be published as part of the Transactions which has been published previous to its presentation.

Sec. 2. Any paper may be published in a medical journal at any time subsequent to its presentation, provided that it be prepared in duplicate, and the original retained in the custody of the Committee of Publication.

Sec. 3. All communications read before the Society shall become its property; but no paper shall be published as part of the Transactions of the Society without its sanction.

Sec. 4. All discussions shall be strictly confined to the subject of the paper or report, and each speaker shall be limited to a speech of ten minutes, and to one of five minutes if he speaks a second time, and no excess of time shall be allowed except by consent of the Society. The reader of the paper shall be allowed ten minutes at the close of the discussion.

Sec. 5. Each county or local society shall be invited to prepare and discuss, during the year, a paper upon some medical subject, and present it to the Society, at its annual meeting, through its appropriate bureau.

ARTICLE VIII.—Amendments.

These By-Laws may be altered or amended by a vote of two-thirds of the members present at any annual meeting.

ORDER OF BUSINESS.

1. Calling the meeting to order.
2. Address by the President.
3. Roll-call and correction of list of members.
4. Appointment of Committee on President's Address.
5. Report of Treasurer.
6. Appointment of Auditing Committee.
7. Report of Corresponding Secretary.
8. Reports of committees.
9. Report of Censors and election of members.
10. Reports of Bureaus.
11. Unfinished business.
12. New business.
13. Election of officers.
14. Announcement of bureaus and committees.
15. Adjournment.

LIST OF MEMBERS.

1885—Allen, John V., M.D., Frankford, Philadelphia.
1870—Allen, J. W., M.D., Altoona.
1883—Allen, Richard C., M.D., 4519 Frankford Ave., Philadelphia.
1885—Arthur, Charles, M.D., Richfield, Kansas.
1889—Ashcraft, Leon, M.D., 1626 Diamond St., Philadelphia.
1889—Bailey, H. W., M.D., 1618 Pacific Ave., Atlantic City, New Jersey.
1883—Baker, Alfred E., M.D., Norwynden Farm, West Chester.
1885—Baker, C. H., M.D., 34 N. 40th Street, Philadelphia.
1888—Baldwin, H. D., M.D., Montrose.
1881—Bartlett, Clarence, M.D., 1506 Arch Street, Philadelphia.
1889—Bayley, Weston D., M.D., 1643 S. Broad St., Philadelphia.
1885—Berkenstock, W. F.. M.D., 1919 Girard Avenue, Phila.
1875—Betts, B. F., M.D., 1609 Girard Avenue, Philadelphia.
1886—Bier, P. A., M.D., 4200 Butler Street, Pittsburgh.
1872—Bigler, W H., M.D., 118 N. 12th Street, Philadelphia.
1873—Bingaman, C. F., M.D., 922 Penn Avenue, Pittsburgh.
1886—Bonnet, Gustav E., M.D., 636 N. 11th Street, Philadelphia.
1872—Bowie, A. P., M.D., 372 Main St., Uniontown.
1844—Boyd, G. S., M.D., Beaver Falls.
1880—Boyd, J. S., New Brighton.
1882—Boyer, Francis W., M.D., Pottsville.
1875—Bradford, L. J., M.D., Sylvania.
1883—Branson, Mary, M.D., 1719 Arch Street, Philadelphia.
1872—Brickley, Obadiah C., M.D., York.
1887—Briggs, E. E., M.D., 20 Washington Avenue, Pittsburgh.
1887—Briggs, H. G., M.D., 20 Washington Avenue, Pittsburgh.

1881—Brooks, Charles M., M.D., 1613 N. 10th St., Philadelphia.
1883—Brown, Samuel, M.D., 651 N. Tenth Street, Philadelphia.
1891—Brown, Wm. K., M.D., 1311 N. Broad St., Philadelphia.
1891—Brown, C. H., M.D., 1820 Diamond St., Philadelphia.
1885—Buchman, Francis, M.D., 1609 S. Broad St., Philadelphia.
1879—Buck, M. J. M.D., Altoona.
1886—Bulick, T. M., M.D., Altoona.
1877—Bullard, J. A., M.D., 130 S. Main St., Wilkesbarre.
1881—Bunting, H. M., M.D., Norristown.
1888—Burchfield, S. E., M.D.,803 Ligonier Street, Latrobe.
1891—Burlingame, F. W., M.D., McKeesport.
1866—Burgher, J. C., M.D., 960 Penn Avenue, Pittsburgh.
1889—Caley, Joseph, M.D., Broad and Green Streets, Phila.
1868—Carmany, C. J., M.D., Harrisburg.
1888—Carmichael, T. H., M.D., 4467 Main Street, Germantown, Philadelphia.
1873—Chantler, I. B., M.D., Sewickley.
1875—Chapman, Millie J., M.D., 916 Penn Avenue, Pittsburgh.
1888—Chisolm, H. C., M.D., 528 Penn Street, Huntingdon.
1885—Christine, G. Maxwell, M.D., 2043 N. 12th Street, Phila.
1891—Cleeland, J. S., M.D., Freeport.
1889—Clark, Anna C., M.D., Allentown.
1886—Closson, J. H., M.D., 70 W. Chelten Avenue, Germantown, Philadelphia.
1883—Coe, Sarah J., M.D., Wilkesbarre.
1873—Cook, I. Elmer, M.D., Harrisburg.
1889—Coolidge, J. W., M.D., Scranton.
1889—Cooper, Isaac, M.D., Trenton, N. J.
1887—Cooper, John, M.D., 42 N. Diamond Street, Allegheny.
1866—Cooper, J. F., M.D., 105 Arch Street, Allegheny.
1887—Cowley. William, M.D., 6442 Penn Avenue, Pittsburgh.
1882—Cranch, Edward, M.D., 109 W. 9th Street, Erie.
1875—Crawford, J. S., M.D., Greensburg.
1883—Crowther, Isaac, M.D., Chester.
1891—Davis, B. S., M.D., Bellevue.
1883—Davis, E. Everett, M.D., 4321 Aspen Street, Philadelphia.
1882—Dean, E. W., M.D., Braddock.
1885—Deardorff, J. H., M.D., Mechanicsburg.

1866—Detwiller, John J., M.D., Easton.
1879—Detwiller, J. W., M.D., Bethlehem.
1886—Dietz, W. G,. M.D., 21 N. Vine Street, Hazelton.
1878—Dinsmore, S. W. S., M.D , Sharpsburg.
1891—Drake J. C. Merle, M.D., Erie.
1880—Doolittle, E. D., M.D., Easton.
1867—Dudley, Pemberton, M.D., 15th and Master Streets, Phila.
1878—Duff, P. S., M.D., Great Belt.
1882—Du Four, W. M., M.D., 755 W. Third St., Williamsport.
1889—Dumont, Anna E., M.D., 17th St., below Girard Avenue, Philadelphia.
1875—Dunn, James L., M.D., Titusville.
1881—Dunning, T. S., M.D., 1328 N. 15th Street, Philadelphia.
1891—Ely, J., M.D., Washington.
1873—Edmundson, W. F., M.D., 375 Fifth Avenue, Pittsburgh.
1882—Evans, H. J., M.D., Altoona.
1880—Ferson, J. L., M.D., 139 Wylie Avenue, Pittsburgh.
1889—Fickel, J. G., M.D., Carlisle.
1884—Fleming, R. K., M.D., 6217 Station Street, Pittsburgh.
1883—Fornias, Eduardo, M.D., 711 Pine Street, Philadelphia.
1889—Fryer, Nevins W., M.D., 402 S. Broad St., Philadelphia.
1873—Fulton, H. W., M.D., 5949 Penn Avenue, Pittsburgh.
1889—Gangloff, Charles. M.D., 6 S. Main Street, Pittsburgh.
1867—Garvin, John J., M.D., 1546 N. 11th Street, Philadelphia.
1866—Gause, Owen B., M.D., Aiken, S. C.
1886—Gerhart, Joseph M., M.D., 603 N. 12th Street, Phila.
1870—Gessler, C. W., M.D., 1332 S. 5th Street, Philadelpiha.
1879—Getze, G. M., M.D., Tarentum.
1891—Gilbert, Irwin B., M.D., 2027 Columbia Ave., Philadelphia.
1885—Giles, J. William, M.D., Nyack, N. Y.
1891—Goff, Ella D., M.D., 17 Taylor Ave., Allegheny.
1875—Goodno, W. C., M.D., 1733 Chestnut St., Philadelphia.
1875—Graham, D. M., M.D., Chicago, Ill.
1883—Gramm, E. M., M.D., 1433 Girard Ave., Philadelphia.
1867—Gramm, G. E., M.D., Ardmore.
1883—Gramm, Theo. J., M.D., 1409 Hanover Street, Phila.
1889—Gregory, G. W., M.D., Troy.

1886—Griffith, J. J., M.D., Manayunk, Philadelphia.
1888—Griffith, Lewis B., M.D., 2514 Ridge Ave., Philadelphia.
1881—Griffith, Silas, M.D., 1431 Girard Avenue, Philadelphia.
1877—Griffith, W. M., M.D., 2035 Ridge Avenue, Philadelphia.
1886—Grimes, Thomas H., M.D., Sewickley.
1888—Gross, F. O., M.D., 1808 N. 8th Street, Phiiadelphia.
1874—Guernsey, J. C., M.D., 1923 Chestnut St., Philadelphia.
1867—Gumpert, B. Barton, M.D., 840 Franklin Street, Phila.
1886—Gundlach, F. C., M.D., 1722 Sarah Street, Pittsburgh.
1885—Haines, O. S., M.D., 137 N. 15th Street, Philadelphia.
1879—Hall, William D., M.D., Altoona.
1887—Haman, W. A., M.D., Reading.
1889—Hamer, J. H., M.D., 113 S. 16th Street, Philadelphia.
1883—Hancock, Joseph, M.D., 1639 Columbia Avenue Phila.,
1891—Harpel, F. E., M.D., Danville.
1888—Harner, John E., M.D., Honeybrook.
1884—Harris, D. R., M.D., 41 N. Jefferson Street, New Castle.
1883—Hassler, W. A., M.D., 105 N. Eighth Street, Allentown.
1881—Hawley, Annie M., M.D., Pughtown, Chester County.
1883—Helfrich, J. H., M.D., Allentown.
1873—Herron, C. D., M.D., 3505 Butler Street, Pittsburgh.
1882—Hofmann, C. H., M.D., 808 Penn Avenue, Pittsburgh.
1883—Holben, M. J., M.D., Slatington.
1887—Holcombe, J. R., M.D., 1327 Girard Avenue, Phila.
1889—Hoover, G. M., M.D., 46 E. Main St., Mechanicsburg.
1883—Horner, J. Richey, M.D., 79 Arch Street, Allegheny.
1889—Hoy, H. K., M.D., Bellefonte.
1889—Hubbard, C. H., M.D., Millville, N. J.
1880—Humes, J. R., M.D., Hollidaysburg.
1886—Ingersoll, W. K., M.D., 4008 Chestnut Street, Phila.
1882—Ivins, Horace F., M.D., 1319 Arch Street, Philadelphia.
1883—Jackson, Lora C., M.D., 1526 Arch Street, Philadelphia.
1888—Jackson, W. H., M.D., Oil City.
1866—James, Bushrod W., M.D., 18th and Green Sts., Phila.
1885—James, Horace E., M.D., 1411 S. Broad Street, Phila.
1867—James, John E., M.D., 1521 Arch Street, Philadelphia.
1870—James, Walter M., M.D., 1123 Spruce Street, Phila.
1889—Jamison, M. R., M.D., Connellsville.

1888—Jennings, C. B., M.D., Reading.
1881—Johnson, Theodore M., M.D., 200 Susquehanna Ave., Pittston.
1869—Jones, Joseph E., M.D., 113 S. High St., West Chester.
1881—Karsner, Daniel, M.D., 4830 Main Street, Germantown.
1889—Kase, Edmund H., M.D., 1323 Girard Avenue, Phila.
1891—Kaufman, John, M.D., Hazleton.
1885—Keim, William H., M.D., 2015 Ridge Avenue, Phila.
1875—Kern, W. H., M.D., McKeesport.
1884—King, W. D., M.D., 326 Fifth Avenue, Pittsburgh.
1887—Kistler, H. E., M.D., Johnstown.
1891—Kline, D. C., M.D., 209 S. Fifth Street, Reading.
1891—Knauer, J. C., M.D., 233 S. Ninth Street, Reading.
1877—Knerr, C. B., M.D., N. E. cor. 12th and Spruce Sts., Phila.
1873—Koenig, M. J., M.D., Jersey Shore.
1872—Korndœrfer, Aug., M.D., 1728 Green Street, Phila.
1889—Lange, F. W., M.D., 429 Lackawanna Ave., Scranton.
1888—Layman, Alfred, M.D., 1628 N. 18th Street, Phila.
1889—Lazear, Lyttleton Lyon, M.D., Pittsburgh.
1887—Leake, E. N., M.D., Butler.
1891—Leckie, J. W., M.D., Hazleton.
1884—Lee, Charles H., M.D., New Castle.
1891—Lee, W. H., M.D., New Castle.
1873—Lefever, Isaac, M.D., Harrisburg.
1866—Liscomb, P. D., M.D., Beaver Falls.
1868—Macfarlan, Malcolm, M.D., 1805 Chestnut St., Phila.
1886—Maddux, D. P., M.D., Chester.
1883—Maguire, W. T., M.D., Darby.
1877—Malin, William H., M.D., Chestnut Hill, Philadelphia.
1881—Mansfield, J. R., M.D., 4852 Main Street, Germantown.
1886—Marks, W. F., M.D., Reading.
1885—Marsden, Biddle R., M.D., Chestnut Hill, Philadelphia.
1883—Marshall, Anna M., M.D., 1608 Mt. Vernon St., Phila.
1891—Marshall, R. S., M.D., Pittsburgh.
1877—Martin, W. J., M.D., 1712 Carson St., S. S., Pittsburgh.
1878—Mauer, J. M., M.D., Washington.
1888—Mercer, E. W., M.D., 157 N. 15th Street, Philadelphia.
1881—Mercer, Robert P., M.D., 223 W. Third Street, Chester.

1888—Mercer, C. S., M.D., Media.
1888—Messervè, F. W., M.D., 110 N. 15th Street, Phila.
1871—Middléton, Caleb S., M.D., 1523 Girard Avenue, Phila.
1887—Millen, J. C., M.D., Palmyra, N. J.
1877—Miller, Z. T., M.D., 2013 Carson Street, S. S., Pittsburgh.
1883—Mitchell, J. N., M.D., 1222 Walnut Street, Philadelphia.
1875—Mohr, Charles, M.D., 555 N. 16th Street, Philadelphia.
1867—Morgan, John C., M.D., 110 S. 17th Street, Philadelphia.
1889—Morrow, E. H., M.D., 1407 Eleventh Avenue, Altoona.
1891—Mueller, G. A., M.D., 35 N. Diamond Street, Allegheny.
1881—Mullen, S. A., M.D., West Chester.
1883—Mullin, W. P., M.D., 5007 Green Street, Germantown.
1888—Murdock, Robert, M.D., Wilkesbarre.
1891—McCauley, J. C., M.D., Rochester.
1879—McClelland, J. B., M.D., 411 Penn Avenue, Pittsburgh.
1867—McClelland, J. H., M.D., 411 Penn Avenue, Pittsburgh.
1884—McClelland, R. W., M.D., 411 Penn Avenue, Pittsburgh.
1883—McClure, Eliza H. Lang, M.D., 1919 Wallace St., Phila.
1891—McDonald, T. S., M.D., Washington, D. C.
1888—McDowell, Charles H., M.D., 1031 Shackamaxon Street, Philadelphia.
1866—Neville, W. H. H., M.D., 19th and Wallace Sts., Phila.
1891—Norton, Claude R., M.D., 700 N. 40th St., Philadelphia.
1887—Page, Henry A., M.D., 6312 Penn Avenue, Pittsburgh.
1884—Parker, G. W., M.D., 1404 S. 6th Street, Philadelphia.
1883—Parker, T. Ellwood, M.D., Woodbury, N. J.
1870—Parsons, Anson, M.D., Springboro.
1881—Parsons, E. C., M.D., Meadville.
1880—Peach, William, M.D., 76 Monterey St., Allegheny City.
1885—Peacock, William, M.D., 2217 N. 6th St., Philadelphia.
1881—Perkins, C. W., M.D., 403 Broad Street, Chester.
1883—Pettengill, Eliza F., M.D., 300 N. 10th St., Phila.
1889—Phillips, Hibbard S., M.D., 326 Fifth Ave., Pittsburgh.
1891—Phillips, Joseph R., M.D., Erie.
1870—Pierce, W. A. D., M.D., 2004 Mt. Vernon Street, Phila.
1880—Pitcairn, Hugh, M.D., Harrisburg.
1891—Pond, Edward H., M.D., Pittsburgh.
1886—Posey, L. P., M.D., 1132 Arch Street, Philadelphia.

1883—Powell, W. C., Jr., M.D., Bryn Mawr.
1881—Pratt, J. W., M.D., Coatesville.
1871—Pratt, Trimble, M.D., Media.
1875—Ramage, R. Y., M.D., Mansfield Valley.
1872—Rankin, J. S., M.D., 5801 Fifth Avenue, Pittsburgh.
1866—Raue, Charles G., M.D., 121 N. 10th Street, Philadelphia.
1883—Reading, J. H., M.D., 1811 Green Street, Philadelphia.
1886—Reading, L. W., M.D., 528 N. 18th Street, Philadelphia.
1888—Reading, Thomas, M.D., Hatboro.
1886—Reeves, Joseph M., M.D., 1609 Mt. Vernon St., Phila.
1878—Rhinehart, C. C., M.D., Marion Station, Pittsburgh.
1891—Rittenhouse, J. S., M.D., Reading.
1871—Rittenhouse, S. R., M.D., Reading.
1880—Robson, J. W., M.D., Marion Station, Pittsburgh.
1887—Rodes, Joseph, M.D., San Diego, California.
1873—Roseberry, C. I., M.D., Easton.
1883—Ross, S. C., M.D., Scranton.
1883—Rosseau, L. G., M.D., 5412 Penn Avenue, Pittsburgh.
1872—Rutter, J. C., M.D., Bloomsburg.
1888—Sandel, J. H., M.D., 23 Centre Avenue, Plymouth.
1872—Sartain, Harriet J., M.D., 212 West Logan Square, Phila.
1874—Schmucker, F. R., M.D., 228 N. Fifth Street, Reading.
1883—Schreiner, Emma T., M.D., Germantown, Philadelphia.
1889—Schwenk, C. S., M.D., 1319 Jefferson St., Philadelphia.
1880—Scott, S. C., M.D., Pittsburgh.
1886—Seibert, W. A., M.D., Easton.
1868—Seip, C. P., M.D., 636 Penn Avenue, Pittsburgh.
1889—Shallcross, I. G., M.D., 1631 Arch Street, Philadelphia.
1875—Shannon, O. R., M.D., 207 Lacock Street, Allegheny.
1879—Shannon, S. F., M.D., Denver, Col.
1883—Sharkey, W. P., M.D., 1938 Girard Avenue, Phila.
1888—Sharpless, E. S., M.D., N. E. cor. 11th and Ogden Streets, Philadelphia.
1885—Shellenberger, C. N., M.D., 1831 Wallace Street, Phila.
1883—Shemp, P. D., M.D., Philadelphia.
1883—Skeels, J. S., M.D., Albion, Erie Co.
1883—Slough, F. J., M.D., 845 Hamilton Street, Allentown.
1883—Slough, W. C. J., M.D., Emaus.

1880—Smedley, I. G., M.D., 1705 Arch Street, Philadelphia.
1889—Smith, George W., M.D., 1320 Walnut Street, Phila.
1887—Smith, Mary E., M.D., 48 E. Diamond, Allegheny.
1889—Smith, R. C., M.D., 1434 Poplar Street, Philadelphia.
1889—Smith, T. Hart, M.D., 1309 Girard Avenue, Phila.
1887—Snader, E. R., M.D., 140 N. 20th Street, Philadelphia.
1887—Speakman, W. W., M.D., 1921 Chestnut Street, Phila.
1889—Spencer, William, M.D., 1523 Girard Avenue, Phila.
1889—Stafford, C. S., M.D., 2015 N. 19th Street, Philadelphia.
1881—Stambach, H. L., M.D., Santa Barbara, California.
1889—Starr, Pearl, M.D., Bellevue.
1883—Starr, Samuel, M.D., 215 E. Fifth Street, Chester.
1891—Stevens, W. R., M.D., Wilkinsburg.
1883—Stewart, H. Knox, M.D., 810 N. Broad Street, Phila.
1883—Still, Horace, M.D., Norristown.
1885—Strong, J. Wilmer, M.D., 2049 N. 13th Street, Phila.
1889—Strong, Walter, M.D., Philadelphia.
1889—Stubbs, G. P., M.D., Philadelphia.
1888—Sullivan, J. Bailey, M.D., 210 Penn Avenue, Pittsburgh.
1881—Swartz, J. R., M.D., Harrisburg.
1889—Titman, George W., M.D., 5659 Germantown Ave., Phila.
1881—Thatcher, J. W., M.D., 35th and Hamilton Sts., Phila.
1871—Thomas, A. R., M.D., 113 S. 16th St., Philadelphia.
1877—Thomas, Charles Monroe, M.D., 1623 Arch Street, Phila.
1891—Tindall, R. Brooks, M.D., Philadelphia.
1886—Tindall, Van R., M.D., 240 Federal Street, Phila.
1886—Thompson, J. H., M.D., 960 Penn Ave., Pittsburgh.
1887—Thompson, Landreth W., M.D., 1031 Green St., Phila.
1887—Tomlinson, W. H., M.D., 5210 Main St., Germantown.
1891—Tomlin, R. E., M.D., 2113 Franklin Street, Phila.
1888—Tonkin, William, M.D., 938 N. 10th Street, Phila.
1881—Toothaker, C. E., M.D., Wylie Street, Philadelphia.
1881—Umstead, D. B., M.D., Tacony, 23d Ward, Phila.
1887—Uncapha, Elizabeth, M.D., Butler Street, Pittsburgh.
1877—Van Artsdalen, C., M.D., Ashbourne.
1883—Van Baun, W. W., M.D., 419 Pine St., Philadelphia.
1886—Van Deusen, Edwin, M.D., 2101 Tioga St., Phila.
1883—Van Deusen, Josephine, M.D., 21st and Tioga Sts., Phila.

1881—Van Lennep, W. B., M.D., 1421 Spruce Street, Phila.
1889—Vischer, Carl V., M.D., 1429 Poplar Street, Phila.
1867—Walker, Mahlon M., M.D., 12 W. Walnut Lane, Germantown, Philadelphia.
1881—Wareheim, Edward A., M.D., Glen Rock.
1870—Waters, George H., M.D., 474 N. 6th Street, Phila.
1881—Weaver, Chandler, M.D., Fox Chase, 23d Ward, Phila.
1883—Weaver, W. P., M.D., Bristol.
1891—Wesner, M. H., M.D., Houtzdale.
1889—White, Elmer T., M.D.
1870—White, N., M.D., New Castle.
1889—White, R. T., M.D., 53 Jackson Street, Allegheny.
1887—Wilcox, F. P., M.D., Clifton Springs, New York.
1887—Wildman, Elias, M.D., Yardley.
1866—Willard, L. H., M.D., cor. Allegheny and Western Avenues, Allegheny City.
1881—Williams, H. E., M.D., Coatesville.
1866—Williams, Thomas C., M.D., 567 N. 5th Street, Phil a.
1873—Williamson, M. S., M.D., 1311 Arch Street, Phila.
1870—Willets, William, M.D., Williamsport.
1886—Wilson, C. A., M.D., cor. Western and Allegheny Avenues, Allegheny City.
1887—Wolfe, W. W., M.D., 35 North Diamond St., Allegheny.
1883—Wood, H. C., M.D., West Chester.
1883—Yearsley, William, M.D., 1532 N. 13th Street, Phila.
1888—Yocum, C. A., M.D., 365 Chestnut Street, Pottstown.
1880—Yoder, D., M.D., Catasauqua.
1874—Young, J. H., M.D., 1630 Green Street, Philadelphia.

HONORARY MEMBERS.

1883—Allen, H. C., M.D., Ann Arbor, Mich.
1868—Dake, Jabez P., M.D., Nashville, Tenn.
1866—Doran, Charles R., M.D., Jacksonville, Fla.
1886—Dowling, John W., M.D., 6 E. 43d St., New York City (deceased).
1868—Helmuth, William Tod, M.D., 158 W. 59th Street, New York.
1885—Houghton, Henry C., M.D., 12 W. 39th St., New York City.
1876—Jones, S. A., M.D., Ann Arbor, Mich.
1876—Lilienthal, S., M.D., 1316 Van Ness Street, San Francisco, Cal.
1868—Paine, H. M., M.D., 106 State Street, Albany, N. Y.
1883—Phillips, W. A., M.D., Cleveland, Ohio.
1868—Rockwith, F. A., M.D., East Saginaw, Mich.
1868—Talbot, I. T., M.D., 66 Marlborough St., Boston, Mass.

CORRESPONDING MEMBERS.

1873—Alvarez, Paz, M.D., Madrid, Spain.
1873—Chauvet, Fernand, M.D., Tours, France.
1873—Eidherr, Francis, M.D., Vienna, Austria.
1883—Hughes, Richard, M.D., Brighton, England.
1873—Pope, Alfred C., M.D., London, England.

NECROLOGICAL LIST.

1866—Ashton, A. H., M.D., died February 18th, 1883.
1866—Barnaby, John E., M.D., died January 5th, 1869.
1867—Barrett, Charles B., M.D., died June 5th, 1871.
1882—Bernard, H., M.D., died ————
1866—Blakely, W. James, M.D., died January 14th, 1877.
1870—Bratt, Benjamin R., M.D., died January 31st, 1872.
1866—Brooks, Silas S., M.D., died July 2d, 1871.
1883—Burr, Richard, M.D., died March 30th, 1885.
1873—Caruthers, R. E., M.D., died January 24, 1885.
1868—Charlton, S. T., M.D., died November 9th, 1886.
1863—Childs, William R. M.D., died November 11th, 1888.
1866—Cooke, William H., M.D., died March 11th, 1879.
1866—Cote, M., M.D., died May 29th, 1878.
1866—Cowley, David, M.D., died October 30th, 1886.
1866—Detweiler, Henry, M.D., died April 21st, 1887.
1871—Dreibelbis, David L., M.D., died March 24th, 1872.
1870—Earhart, Jacob R., M.D., died June 23d, 1891.
1870—Farrington, E. A., M.D., died December 17th, 1885.
1866—Friese, Michael, M.D., died February 4th, 1880.
1866—Frost, J. H. P., M.D., died January 21st, 1875.
1866—Gardiner, Richard, M.D., died March 22d, 1877.
1883—Gause, Percival O. B., M.D., died November 10th, 1887.
1877—Grumbeid, William, M.D., died ————
1866—Guernsey, H. N., M.D., died June 27th, 1885.
1870—Guernsey, W. F., M.D., died February 16th, 1877.
1888—Hawley, S. B., M.D., died March 6th, 1890.
1886—Herron, James A., M.D., died November 15th, 1868.
1866—Hofmann, Herman H., M.D., died April 4th, 1891.
1884—Hosfeld, George, M.D., died November 9th, 1884.
1873—Houard, J. G., M.D., died April 24th, 1878.
1866—James, David, M.D., died June 6th, 1873.
1886—Jeanes, Jacob, M.D., died December 18th, 1877.
1866—Koch, Augustus W., M.D., died May 4th, 1886.

1866—Lee, J. K., M.D., died November 10th, 1887.
1869—Lee, John K., M.D., died May 31st, 1889.
1867—Lippe, Adolph, M.D., died January 23d, 1888.
1871—Lovejoy, E., M.D. (honorary), died August 15th, 1872.
1868—Malin, George W., M.D., died January 18th, 1883.
1886—Malin, John, M.D., died November 29th, 1889.
1866—Marsden, J. H., M.D., died August 27th, 1883.
1865—Martin, Henry Noah M.D., died September 1st, 1889.
1839—May, Newton, M.D., died January 27th, 1889.
1866—McClatchey, R. J., M.D., died January 15th, 1883.
1870—Moore, Thomas, M.D., died March 25th, 1882.
1873—Nichol, Thomas, M.D. (corresponding), died June 14th, 1890.
1869—Ostrander, W. M., M.D., died August 23d, 1881.
1868—Payne, Wm. E., M.D. (honorary), died March 9th, 1877.
1878—Pereira, Ignacio, M.D. (corresponding), died April 18th, 1881.
1868—Pfoutz, J. S., M.D., died ————
1866—Preston, Coates, M.D., died August 9th, 1881.
1868—Poulte, J. H., M.D. (honorary), died February 24th, 1884.
1882—Pursel, J. E., M.D., died March 15th, 1885.
1853—Reading, Edward, M.D., died March 7th, 1889.
1866—Reading John R., M.D., died February 14th, 1866.
1870—Reinhold, H. E., M.D., died March 6th, 1879.
1866—Roberts, R. Ross, M.D., died April 4th, 1875.
1866—Rosseau, L. M., M.D., died September 25th, 1882.
1872—Scott, James L., M.D., died August 15th, 1876.
————Spencer, J. H., M.D., died ————.
1872—Speth, W. F., M.D., died May 11th, 1881.
————Stauffer, D. R., M.D., died March 16th, 1874.
1867—Stevens, C. A., M.D., died January 17th, 1881.
1870—Taudte, F., M.D., died March 27th, 1878.
1882—Trites, W. B., M.D., died January 19th, 1890.
1880—Way, J. H., M.D., died September 3d, 1887.
1866—Williamson, Walter M., M.D., died December 19th, 1870.
1866—Williamson, Walter, M.D., died May 5th, 1874.
1848—Wood, James B., M.D., died April 14th, 1889.
1880—Zerns, William M., M.D., died September 21st, 1887.

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